REQUEST FOR PROPOSALS (RFP)

Dental Services under the Children's Health Insurance Program Reauthorization Act (CHIPRA)
for
LaCHIP Affordable Plan Members

MEDICAL VENDOR ADMINISTRATION
LOUISIANA MEDICAID PROGRAM
DEPARTMENT OF HEALTH AND HOSPITALS

JUNE 15 2010

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GLOSSARY

Business Day – Traditional workdays, which are Monday, Tuesday, Wednesday, Thursday and Friday. State holidays are excluded.

Calendar Days — All seven (7) days of the week. Unless otherwise specified, the term "days" in this RFP refers to calendar days.

Centers for Medicare and Medicaid Services (CMS) - Formerly the Health Care Financing Administration of the federal Department of Health and Human Services.

CHIP – The Children's Health Insurance Program created under Title XXI of the federal Social Security Act.

Children's Health Insurance Program Reauthorization Act (CHIPRA) –Federal law that requires states with separate Children's Health Insurance Programs, like the LaCHIP Affordable Plan, to provide coverage of dental items and services
Claim - A request for payment for benefits received or services rendered.

Clean Claim – A claim that can be processed without obtaining additional information from the provider of the service or from a third party.

Contract - The written, signed agreement resulting from this RFP.

Member – A person who is enrolled in the Louisiana Children's Health Insurance Program Affordable Plan.

Federally Qualified Health Center (FQHC) - An entity that receives a grant under Section 330 of the Public Health Service Act, as amended. (Also see Section 1905(1) (2) (B) of the Social Security Act.) FQHCs provide primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services.

Fraud – As relates to Medicaid Program Integrity means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him or some other person. It includes any act that constitutes fraud under applicable federal or state law. Fraud may include deliberate misrepresentation of need or eligibility; providing false information concerning costs or conditions to obtain reimbursement or certification; or claiming payment for services which were never delivered or received.

Good Cause – an acceptable reason for a dental provider to refuse to see a LaCHIP Affordable Plan member. Good Cause can be chronic failure to make appointments, and threatening behavior to a provider, provider's staff, or other clients in the provider's office.

HIPAA – The federal Health Insurance Portability and Accountability Act of 1996.

LaCHIP Affordable Plan (Phase V) – Louisiana's separate state CHIP (Title 21) program that provides health coverage to uninsured children in families with income from 201% up to and including 250% of the Federal Poverty Level. At present, the program is administered by the Louisiana Office of Group Benefits.

Liquidated Damages – Damages that may be assessed whenever the Dental Plan, its providers, or its subcontractors fails to achieve certain performance standards and other items defined in the terms and conditions of the Dental Plan's contract.

Louisiana Medicaid State Plan - The written agreement between the Louisiana Department of Health and Hospitals and CMS which describes how the Medicaid program is administered and which acts as a binding agreement between the Department of Health and Hospitals and CMS.

Medicaid - A means tested federal-state entitlement program enacted in 1965 by Title XIX of the Social Security Act Amendment. Medicaid offers federal matching funds to states for costs incurred in paying health care providers for serving covered individuals.

Medical Vendor Administration (MVA) – Refers to the name for the budget appropriate unit specified in the Louisiana state budget which contains the Bureau of Health Services Financing (Louisiana's single state Medicaid agency).

Member Month – A month of coverage for a LaCHIP Affordable Plan member.

Must- Denotes a mandatory requirement.

Dental Plan – A collective group of dental health care providers (i.e., individuals, agencies or organizations) that have been assembled to provide oral health care services.

Network Providers – An individual, agency, or organization that is currently contracted with the Dental Plan or will be in the future, to provide oral health care services to LaCHIP Affordable Plan members.

Notice of Termination - A written notice issued by the Louisiana Department of Health and Hospitals to the Dental Plan terminating all or part of the contract.

Per Member Per Month (PMPM) – The amount of money paid or received on a monthly basis for each individual enrolled.

Performance Measures – Specific operationally defined performance indicators using data to track performance and quality of care and identify opportunities for improvement on important dimensions of care and service.

Preventive Care – Refers to the treatment to avert disease/illness and/or its consequences. The term is used to designate prevention and early detection programs rather than restorative or treatment programs.

Protected Health Information (PHI) – Individually identifiable health information that is maintained or transmitted in any form or medium and for which conditions for disclosure are defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and 45 CFR Part 160 and 164

Quality Assessment and Performance Improvement Program (QAPI Program) – Program that objectively and systematically defines, monitors and evaluates the quality and appropriateness of care and services and promotes improved patient outcomes through performance improvement projects, medical record audits, performance measures, surveys, and related activities.

Redacted Proposal- The removal of confidential and/or proprietary information from one copy of the proposal for public records purposes.

Remittance Advice – An electronic listing of claims submitted to billing providers which detail claims adjudication.

Rural Health Clinic (RHC) – A clinic that is located in an area that has a healthcare provider shortage that provides primary health care and related diagnostic services and may provide dental, optometric, podiatry, chiropractic and behavioral health services; and which must be reimbursed on prospective payment system

School Based Health Centers (SBHC) –A facility physically located in a school or on or near school grounds that provides convenient access to comprehensive, primary and preventive physical and mental health services for public school students.

Pre-Certification- The approval of or concurrence with the treatment plan proposed by a participating dental professional before the provision of service. Under some plans, pre-certification by the carrier is required before certain services can be provided/The term Pre-certification may be used interchangeably with Prior Authorization.

Shall- Denotes a mandatory requirement

Should- Denotes a preference but not a mandatory requirement.

Social Security Act - The current version of the Social Security Act of 1935 (42 U.S.C.A. § 301 et seq.) as amended which encompasses the Medicaid Program (Title XIX) and CHIP Program (Title XXI).

Solvency- Minimum standard of financial health for the Dental Plan, where assets exceed liabilities and the Dental Plan can meet timely payment requirements

Special Needs- Any medically compromising condition requiring wheelchair access, anesthesia or significant monitoring to facilitate the provision of dental treatment. Conditions may include, but are not limited to, developmental disabilities, behavioral problems, hemophilia, cerebral palsy, HIV and active acquired immune deficiency syndrome (AIDS).

State Fiscal Year (SFY) – The period of time between July 1 and June 30 of the following calendar year.

State - state of Louisiana.

State Plan – Refers to the Louisiana Medicaid State Plan

Subcontract - An agreement between the Dental Plan and a provider of health care services to furnish covered services to members, or with a marketing organization, or with any other organization or person who agrees to perform any administrative function or service for the Dental Plan specifically related to fulfilling the Dental Plan's obligations under the terms of this RFP and the contract between DHH and the Dental Plan.

Subcontractor - A person, agency or organization with which the Dental Plan has contracted or delegated some of its management functions or other contractual responsibilities to provide covered services to its members.

Title XXI of the Social Security Act - The Federal law establishing the State Children's Health Insurance Program (CHIP).

Utilization Management (UM) – Refers to the process to evaluate the medical necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Also know as Utilization Review.

Will- Denotes a mandatory requirement

ACRONYMS

Automatic Call Distribution (ACD)
Centers for Medicare and Medicaid Services (CMS)
Children's Health Insurance Program Reauthorization Act (CHIPRA)
Code of Federal Regulations (CFR)
Department of Health and Hospitals (DHH)
Federal Employees Health Benefit Plan (FEHBP)
Federal Poverty Level (FPL)
Federally Qualified Health Center (FQHC)
Healthcare Effectiveness Data and Information Set (HEDIS)
Louisiana Children's Health Insurance Program (LaCHIP)
Medical Eligibility Determination System (MEDS)
Medical Vendor Administration (MVA)
Office of Group Benefits (OGB)
Per Member Per Month (PMPM)
Request for Proposals (RFP)

1. GENERAL INFORMATION

1.1. BACKGROUND

1.1.1. The mission of the Department of Health and Hospitals (DHH) is to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the state of Louisiana. DHH is dedicated to fulfilling its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner.

1.1.2. DHH is comprised of the Medical Vendor Administration (MVA), the Office for Citizens with Developmental Disabilities, the Office of Mental Health, the Office for Addictive Disorders, the Office of Aging and Adult Services, and the Office of Public Health. Under the general supervision of the Secretary, these principal offices perform the primary functions and duties assigned to DHH.

1.1.3. DHH, in addition to encompassing the program offices, has an administrative office known as the Office of the Secretary, a financial office known as the Office of Management and Finance, and various bureaus and boards. The Office of the Secretary is responsible for establishing policy and administering operations, programs, and affairs.

1.1.4. In 1965, the federal health insurance program known as Medicaid was created with the passage of Title XIX of the Social Security Act. Since that time it has become the nation's major public financing program for healthcare coverage of uninsured, low-income families, and long-term care of low-income elderly and disabled people. Medicaid coverage groups include uninsured pregnant women and children, members of families with a dependent child, those who are disabled or blind and those aged 65 or older. Funded by both the federal and state government, Medicaid covers a wide range of services. In Louisiana, Medicaid is administered by DHH, Medical Vendor Administration.

1.1.5. MVA, by combination of state and federal funds, makes payment for medical services rendered by enrolled Providers to eligible recipients. The Program's benefits are designed to be in compliance with Title XIX of the Social Security Act of 1965, as amended. MVA includes Medicaid of Louisiana (Title XIX) as authorized by the Social Security Act and

amendments, State-funded medical categories authorized by the Louisiana Legislature and Licensing and Certification.

1.1.6. DHH is also charged with the operation of the Louisiana Children's Health Insurance Program (LaCHIP), which is authorized by Title XXI of the Social Security Act. LaCHIP is funded through a combination of state funds and enhanced federal match and consists of a Medicaid expansion CHIP program for uninsured children in families up to 200% of the federal poverty level (FPL) and a separate LaCHIP program called LaCHIP Affordable Plan for uninsured children in families with income between 201% and 250% of the FPL. Both programs provide medical coverage to children who are not eligible for Medicaid and who do not have private health insurance.

1.1.7. The LaCHIP Affordable Plan is a stand-alone program (e.g. non Medicaid expansion) that provides comprehensive health care coverage to children up to the age of nineteen (19). Currently, DHH contracts with the Office of Group Benefits (OGB), the agency that administers the state employees' health plan, to administer payment for health care services for this population. As of February 27, 2010, there were 2,882 LaCHIP Affordable Plan members. Families enrolled in this program are required to contribute a premium of $50 per month, regardless of the number of children.

1.1.8. The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009, P.L. 111-3, requires states with separate Children's Health Insurance Programs, like the LaCHIP Affordable Plan, to provide coverage of dental items and services. Members pay a monthly premium to OGB for medical benefits. There is no additional cost to the members for the added dental coverage.

1.2. PURPOSE OF REQUEST FOR PROPOSAL (RFP)

1.2.1. The purpose of this RFP is to solicit proposals from qualified proposers to provide Dental Plan coverage to include the administration and delivery of comprehensive dental care for children enrolled in the LaCHIP Affordable Plan. Proposers are encouraged to propose new and efficient methods for providing dental services to members in a cost effective manner.

1.3. INVITATION TO PROPOSE

1.3.1. DHH is inviting qualified proposers to submit a proposal for dental services as required under CHIPRA for LaCHIP Affordable Plan members. Consideration will be limited to proposers who submit proposals in accordance with all specifications and conditions set forth herein.

1.4. QUALIFICATIONS TO PROPOSE

1.4.1. DHH is soliciting proposals from qualified proposers meeting the following requirements:

1.4.1.1. Must possess a minimum of five (5) years experience, within the past ten (10) years, administering dental plans for children;

1.4.1.2. Successfully implemented similar dental projects; and

1.4.1.3. Possess or will secure a certificate of authority in the state of Louisiana to transact health and accident insurance.

1.5. RFP MONITOR

1.5.1. Requests for copies of the RFP and written questions or inquiries must be directed to the RFP Monitor listed below:

Rene Huff, Medicaid Program Monitor
Louisiana Department of Health and Hospitals
Medical Vendor Administration
Bienville Building
628 North 4th St.
6th Floor
Baton Rouge, LA 70802
Telephone: 225.342.4963
FAX : 225.376.4733
Email: rene.huff@la.gov

1.5.2. This RFP is available in PDF at the following weblink:
http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 .
http://www.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4

1.5.3. All communications relating to this RFP must be directed to the DHH RFP contact person named above. All communications between Proposers and other DHH staff members concerning this RFP are strictly prohibited.

Failure to comply with these requirements may result in proposal disqualification.

1.6. PROPOSER QUESTIONS

1.6.1. DHH will consider written questions regarding the requirements of the RFP or Scope of Work to be provided before the date specified in the Schedule of Events. To be considered, written questions and requests for clarification of the content in this RFP must be received at the above address, fax number, or email address by the date specified in the Schedule of Events. Any and all such written questions directed to the RFP Monitor will be deemed to require an official response. All questions must be labeled DENTAL RFP or they will not be accepted.

1.6.2. A copy of all questions and responses to all written questions will be posted by the date specified in the Schedule of Events to both of the following weblinks:

http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 and
http://www.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4

1.6.3. Action taken as a result of verbal discussion shall not be binding on DHH. Only written communication and clarification from the RFP Monitor shall be considered binding.

1.7. PRE-PROPOSAL CONFERENCE (NOT REQUIRED FOR THIS RFP)

1.8. SCHEDULE OF EVENTS

(DHH reserves the right to deviate from this Schedule of Events)

Schedule of Events	
Public Notice of RFP	*June 15, 2010*
Deadline for Receipt of Written Questions	*June 23, 2010*
Response to Written Questions	*June 30, 2010*
Deadline for Receipt of Proposals	*July 20, 2010*
	July 23, 2010-

Proposal Evaluation	*August 3, 2010*
Contract Award Announced	*August 6, 2010*
Contract Negotiations Begin	*August 9, 2010*
Contract Begins	*November 1, 2010*

1.9. RFP ADDENDA

1.9.1. In the event it becomes necessary for DHH to revise any portion of the RFP for any reason, DHH shall post addenda, supplements, and/or amendments to all potential proposers known to have received the RFP. Additionally, all such supplements shall be posted at the following web address:

http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 and
http://wwwprd.doa.louisiana.gov/OSP/LaPAC/bidlist.asp?department=4

2. SCOPE OF WORK

2.1. PROJECT OVERVIEW

2.1.1. The Centers for Medicare and Medicaid Services (CMS) allows states to develop a state-designed benefit plan to utilize dental coverage that is equivalent to the Federal Employees Health Benefit Plan (FEHBP), State Employee Dependant Dental Coverage or coverage offered through a Commercial Dental Plan. DHH has selected the FEHBP Standard Option to satisfy CHIPRA requirements.

2.1.2. Scope of services includes, but is not limited to, the following:

2.1.2.1. Provide coverage of dental services to prevent disease and promote oral health; restore oral structures to health and function; and treat oral health emergency conditions;

2.1.2.2. Enroll, train and support a network of qualified dental providers adequate to provide access to dental care for all members;

2.1.2.3. Maintain records for a minimum of six (6) years from date of service;

2.1.2.4. Maintain quality control procedures and programs;

2.1.2.5. Furnish regular performance reports;

2.1.2.6. Operate separate toll free member and provider telephone hotlines;

2.1.2.7. Develop, implement and maintain a system for tracking and resolving complaints and appeals of both members and providers; and

2.1.2.8. Engage in dental education and member outreach campaigns at a minimum annually, which may include reminders of the necessity for periodic dental services. Campaigns at a minimum annually, which may include reminders of the necessity for periodic dental services.

2.1.3. The Dental Plan shall provide comprehensive dental services to LaCHIP Affordable Plan members which prevents disease and promotes oral health.

2.2. DELIVERABLES

2.2.1. Staffing Requirements

2.2.1.1. The Dental Plan shall maintain normal business hours (8 a.m. to 5 p.m. Central Time), Monday through Friday with the exception of recognized Louisiana state holidays.

2.2.1.2. The Dental Plan shall not have an employment, consulting, or any other agreement with a person that has been debarred or suspended by any federal agency for the provision of items or services that are significant and material to the entity's contractual obligation with DHH.

2.2.1.3. The Dental Plan's staff shall be trained. The Dental Plan shall provide electronic copies of all training materials and a description of methods used for training staff at least one month before the start of the contract and annually thereafter. DHH reserves the right to approve or reject all hires to program management level positions.

2.2.1.4. The Dental Plan shall identify in writing the name and contact information for all personnel at the implementation of the program. See **Sections 2.2.4.3.8 and 5.3.1** of this RFP regarding replacement or substitution of personnel.

2.2.1.5. DHH reserves the right to require the Dental Plan to select a different applicant for Key Management Personnel positions. The Dental Plan shall notify DHH for approval of any changes in these Key Management positions during the term of the contract in writing within ten (10) business days of a change.

2.2.1.6. Reductions in staffing levels may only be made with the prior written approval of DHH. The Dental Plan shall not maintain positions deemed nonessential for the purpose of maintaining the current reimbursement level.

2.2.1.7. The Dental Plan's failure to comply with staffing requirements as described in this RFP may result in the application of immediate sanctions as specified in the Liquidated Damages section (2.2.32)

of this RFP.

2.2.1.8. Complaints received by the Dental Plan regarding any conflict of interest or inappropriate conduct of the Dental Plan's staff must be followed by a written report of the incident to DHH within two (2) business days of the reported complaint.

2.2.1.9. The Dental Plan will be required to provide malpractice insurance for all medical professionals including Dentists.

2.2.2. Responsibilities and Qualifications

2.2.2.1. The specific responsibilities and minimum qualifications of Key Management Personnel and Staff are described in the following sections. Where it is appropriate to establish such requirements, the minimum staffing levels, responsibilities, and qualifications of personnel are described.

2.2.3. <u>Key Management Personnel</u>

2.2.3.1. Project Director

2.2.3.1.1. *Project Director Responsibilities*

2.2.3.1.1.1. The Project Director shall be assigned to the contract and be responsible for the administration of the contract. The Project Director shall serve as the liaison to DHH by communicating with DHH's Contract Monitor. The Project Director shall be responsible for the coordination and operation of all aspects of the contract, including coordinating all meetings between key stakeholders and DHH. The Project Director shall be responsible for management of the daily operations of the contract in an orderly and efficient manner, including such functions as enrollment, information, administration, and reporting. The Project Director shall be available to respond immediately to requests from DHH's Contract Monitor and DHH Administration.

2.2.3.1.2. ***Project Director Qualifications (Mandatory)***

2.2.3.1.2.1. Bachelor's degree from a four (4) year accredited college or university.

2.2.3.1.2.2. Not prohibited from participating in any federal or state funded healthcare programs.

2.2.4. Key Management Team Staff

2.2.4.1. Full-Time Administrator

2.2.4.1.1. The Dental Plan shall have a full-time administrator specifically identified to administer the day-to-day business activities related to the contract. The Dental Plan may designate the same person as the Project Director, the Administrator, or the Dental Director, but such person cannot be designated to any other position in this section.

2.2.4.2. Dental and Professional Support Staff

2.2.4.2.1. The Dental Plan shall have dental and professional support staff sufficient to conduct daily business in an orderly manner including having member services staff directly available during business hours for member services consultations, as determined through management and dental reviews. The Dental Plan shall maintain sufficient dental staff, available twenty-four (24) hours a day, seven (7) days a week, to handle emergency services and care inquiries. This may include:

2.2.4.2.1.1. Dental Director,
2.2.4.2.1.2. Clinical Services Coordinator,
2.2.4.2.1.3. Clinical Auditor,
2.2.4.2.1.4. Medical Records Review Coordinator,
2.2.4.2.1.5. Data Processing and Data Reporting Coordinator,
2.2.4.2.1.6. Member Education and Marketing Coordinator,
2.2.4.2.1.7. Quality Management Professional,
2.2.4.2.1.8. Utilization Management,
2.2.4.2.1.9. Complaints and Appeals Coordinator,
2.2.4.2.1.10. Compliance Officer,
2.2.4.2.1.11. Utilization Management Staff, and

2.2.4.2.1.12. Claims Manager.

2.2.4.3. Dental Plan Staff National Background Check

2.2.4.3.1. All temporary, permanent, subcontracted, part-time and full-time Dental Plan staff working on Louisiana Medicaid contracts must have national criminal background checks prior to starting work on the contract. The results shall include all felony convictions and shall be submitted to DHH for review prior to the start of work on the contract.

2.2.4.3.2. Any employee with a background unacceptable to DHH must be prohibited from working on Louisiana Medicaid contracts or immediately removed from the project by the Dental Plan. Examples of felony convictions that are unacceptable include but are not limited to those convictions that represent a potential risk to the security of data systems and/or Protected Health Information (PHI), potential for healthcare fraud, or pose a risk to the safety of others.

2.2.4.3.3. The national criminal background checks must also be performed every two (2) years for all temporary, permanent, subcontracted, part-time and full-time Dental Plan staff working on Louisiana Medicaid contracts beginning with the 25th month following contract award. The Dental Plan will be responsible for all costs to conduct the criminal background checks.

2.2.4.3.4. The Dental Plan shall provide the results of the background checks, in a report upon its completion, to DHH on only those employees currently employed on the contract. The format of the report shall be approved by DHH and shall include all copies of background checks as an appendix to the report.

2.2.4.3.5. The Dental Plan must ensure that all entities or individuals, whether defined as “Key Personnel” or not, performing services under contract with Louisiana Medicaid are not “Ineligible Persons” to participate in the Federal health care programs or in Federal procurement or non-procurement programs or have been convicted of a criminal offense that falls within the ambit of 42 U.S.C 1320a-7(a), but has not yet been excluded, debarred, suspended, or otherwise declared ineligible. Exclusion lists include Department of Health and Human Services/ Office of Inspector General List of Excluded Individuals/Entities (available via the internet at http://www.oig.hhs.gov) and the General Services

Administration's List of Parties Excluded from Federal Programs (available via the Internet at http://www.epls.gov).

2.2.4.3.6. All temporary, permanent, subcontract, part-time and full-time Dental Plan staff working on Louisiana Medicaid contracts must complete an annual statement that includes an acknowledgement of confidentiality requirements and a declaration as to whether the individual has been convicted of a felony crime or has been determined an "Ineligible Person" to participate in Federal healthcare programs or in Federal procurement or non-procurement programs.

2.2.4.3.7. The Dental Plan shall keep the individual statements on file and submit a comprehensive list of all current staff in an annual statement to DHH, indicating if the staff stated they were free of convictions or ineligibility referenced above.

2.2.4.3.8. If the Dental Plan has actual notice that any temporary, permanent, subcontract, part-time, or full-time Dental Plan staff has become an "Ineligible Person" the Dental Plan shall remove said personnel immediately from any work related to this procurement and notify DHH on the same date the notice of a conviction or ineligibility is received. For felony convictions, DHH will determine if the individual should be removed from the contract project permanently.

2.2.5. Toll-free Telephone Line

2.2.5.1. The Dental Plan shall maintain a toll-free Automatic Call Distribution (ACD) system which evenly distributes incoming calls from members and providers. The call center shall operate in English, Spanish, and Vietnamese. Translation services shall be available upon demand.

2.2.5.2. The ACD system shall monitor the activity of every representative and be capable of routing calls to the appropriate representative.

2.2.5.3. The ACD system shall track all call data for reports.

2.2.5.4. The ACD system shall monitor system and representative performance by tracking the following:

2.2.5.4.1. Number of incoming calls on each line;

2.2.5.4.2. Length of time each call spends in queue ;

2.2.5.4.3. Number of calls answered by representatives or abandoned by callers before they are answered; and

2.2.5.4.4. Amount of representative time spent on various ACD activities.

2.2.5.5. The ACD system shall recognize inbound calls and promptly answer and distribute the call to the first available customer service representative. Call hold time is monitored, and staff availability is rerouted based on queue data.

2.2.5.6. The Dental Plan, through the ACD system, shall generate reports with statistics on all incoming calls, including the amount of time that a call has been holding, and the number of busy signals, or abandoned calls in the system. The Dental Plan shall submit reports to DHH upon request, including information pertaining to individual calls. The Dental Plan shall analyze the reports and make appropriate adjustments to call center resources, as necessary to meet requirements stated in Section 2.2.14.2 of the RFP.

2.2.5.7. Customer Service representatives in the Dental Plan's call center shall be available to answer member and provider calls from 8 a.m. to 5 p.m., Central Standard Time, Monday through Friday (excluding state designated holidays). The representatives shall assist members with requests including, but not limited to:

2.2.5.7.1. Provider contact information;

2.2.5.7.2. Benefit and copayment information; and

2.2.5.7.3. Need for additional identification cards and member handbooks.

2.2.5.8. Providers who call the Call Center shall receive assistance in areas such as:

2.2.5.8.1. Status of pre-certification requests;

2.2.5.8.2. Member benefits;

2.2.5.8.3. Claims; and

2.2.5.8.4. Payments.

2.2.5.9. Members and providers shall be able to obtain information on demand from the Dental Plan's automated Interactive Voice Response (IVR) system on a 24/7 basis, except for periodic maintenance. The IVR system shall offer fax-on-demand capabilities for members and providers.

2.2.5.10. At any time, the caller shall be able to press "0" to be connected to a representative rather than accessing information through the IVR. After regular business hours, the toll-free number shall be answered by the IVR system. In the event that automated assistance is not available, the system shall inform callers about operating hours, alternatives for communicating with the Dental Plan and what to do in an emergency. The Dental Plan shall provide information for after hour emergencies.

2.2.6. Access

2.2.6.1. The Dental Plan shall be committed to increasing the availability of dental care services so that members have the most comprehensive dental care and the most convenient access possible to dental network providers. The following strategies to ensure that this goal is met shall include the following:

2.2.6.1.1. Create and maintain a statewide network of providers

2.2.6.1.2. Ensure that network providers are within adequate proximity to members by arranging for dental services to be provided from the closest clinically appropriate dentist available.

2.2.6.2. The Dental Plan shall monitor the network on a quarterly basis to maintain a high level of access to dental providers. The following methods must be used to assess the continuing effectiveness of the network:

2.2.6.2.1. Geographic accessibility reports and analysis,

2.2.6.2.2. Anticipated or actual changes in enrollment trends,

2.2.6.2.3. Monitoring, tracking, and responding to member complaints related to network services,

2.2.6.2.4. Dentist availability to members for routine and emergency care, and

2.2.6.2.5. Feedback from members, providers, and customers regarding access to care.

2.2.6.3. The Dental Plan shall offer members assistance in locating a provider, and scheduling an appointment. If there are no in-network options available, the Dental Plan must make an effort to reach out to out-of-network providers and negotiate rates for needed services.

2.2.7. Special Needs

2.2.7.1. Special needs are defined as any medically compromising condition requiring wheelchair access, anesthesia or significant monitoring to facilitate the provision of dental treatment. Conditions may include, but are not limited to, developmental disabilities, behavioral problems, hemophilia, cerebral palsy, HIV and active acquired immune deficiency syndrome (AIDS).

2.2.7.2. The Dental Plan shall develop an approach to match the type of special service needed to best meet the dental needs of the members' developmental, behavioral or health status that warrants unique services. In response to a member or a referring provider, staff must work closely with the member and/or his or her representative to arrange delivery of covered services. All such interactions shall comply with HIPAA provisions.

2.2.8. Services

2.2.8.1. Benefit Package equivalent to FEBHP

2.2.8.1.1. The Dental Plan shall provide dental coverage that is equivalent to the Federal Employees Health Benefit Plan (FEHBP) satisfying CHIPRA requirements.

2.2.8.1.2. The Dental Plan shall maintain a statewide network of

qualified and licensed dental care providers. The Dental Plan shall include the following:

2.2.8.1.2.1. Dental benefit coverage for children that includes preventative visit(s), exams, x-rays, cleaning, basic restorative, and treatment services based on cost effective, evidence-based standards of practice within the dental community;

2.2.8.1.2.2. Identification of any caps and/or limitations to the benefit package;

2.2.8.1.2.3. A list of services that require pre-certification; and

2.2.8.1.2.4. Current Dental Terminology Codes (CDT) that will be included in the insurance coverage.

2.2.8.2. Out-of-network services

2.2.8.2.1. If a member receives services from a provider who is out of the Dental Plan's network without authorization from the Dental Plan, the member will be responsible for the full cost of the service.

2.2.8.3. Dental emergencies

2.2.8.3.1. The Dental Plan shall develop an emergency service policy and submit this to DHH for approval.

2.2.9. Enrolling Providers

2.2.9.1. The Dental Plan shall recruit providers who meet the clinical, geographic, cultural and linguistic needs of LaCHIP Affordable Plan members. All providers who contract with the Dental Plan to serve population not covered by this RFP must be required to serve LaCHIP Affordable Plan members.

2.2.9.2. The Dental Plan shall make a good faith attempt to enroll FQHCs and RHCs as network providers.

2.2.9.3. The Dental Plan shall reduce the administrative burden associated with government-sponsored programs. The Dental Plan may accomplish this through responsive customer service, leading-edge web functionality, and quick and accurate claims payments.

2.2.10. Credentialing

2.2.10.1. Providers participating in the Dental Plan's network must undergo a standard credentialing review prior to acceptance as a network provider. This applies to providers participating in the network at the outset of operations, as well as those added over the course of this contract.

2.2.10.2. Credentialing includes verifying the following, but is not limited to:

2.2.10.2.1. Graduation from an accredited U.S. college of dentistry;

2.2.10.2.2. Verification of state license information;

2.2.10.2.3. Board certification/ eligibility appropriate to practice area;

2.2.10.2.4. Malpractice insurance coverage;

2.2.10.2.5. Collection of information from publicly available sources that may disclose prior problems with malpractice or other complaints;

2.2.10.2.6. Proof of professional liability insurance;

2.2.10.2.7. Certificate of specialty (if applicable);

2.2.10.2.8. Disclosure of disciplinary action by the Louisiana State Dental Board or any other licensing agency;

2.2.10.2.9. Disclosure of litigation;

2.2.10.2.10. Detailed history of general, chemical, and mental health;

2.2.10.2.11. Detailed history of conviction of fraud or felony;

2.2.10.2.12. Review of the U.S. Department of Health and Human Services Office of Inspector General List of Excluded Individuals;

2.2.10.2.13. Review of the Healthcare Integrity and Protection Data Bank;

2.2.10.2.14. Disclosure of revocation, suspension or limitations placed on a Drug Enforcement Agency license;

2.2.10.2.15. Compliance with all state and federal laws; and

2.2.10.2.16. Compliance with OSHA requirements within the office.

2.2.10.3. The Dental Plan shall review each provider for compliance with established criteria. Providers accepted for the Dental Plan's network must sign an agreement that defines their contractual obligations relative to professional conduct and quality of care. The agreement shall define responsibilities for recordkeeping, records retention, reporting and providing the Dental Plan access to the dental facility and its records. In addition, the agreement shall contain a clause that providers may not refuse to treat a LaCHIP Affordable Plan member without good cause.

2.2.10.4. The Dental Plan must, on a monthly basis, monitor state and federal sanction actions to determine if their providers are not debarred by the state or federal government. The Dental Plan must perform cyclical re-credentialing of network providers at a minimum every two years to ensure ongoing compliance with contract requirements.

2.2.11. Dental Records

2.2.11.1. General Requirements

2.2.11.1.1. The Dental Plan shall have policies and procedures to maintain, or require providers and subcontractors to maintain, an individual dental record for each member. The Dental Plan shall ensure the dental records are:

2.2.11.1.1.1. Accurate and legible;

2.2.11.1.1.2. Safeguarded against loss, destruction, or unauthorized use and maintained in an organized fashion for all members evaluated or treated, and accessible for review and audit; and

2.2.11.1.1.3. Readily available for review and provides dental and other clinical data required for Quality and Utilization Management review.

2.2.11.2. The Dental Plan shall ensure the dental record includes, minimally, the following:

2.2.11.2.1. Member identifying information, including name, current address, identification number, date of birth, sex and legal guardianship (if applicable);

2.2.11.2.2. Primary language spoken by the member and any translation needs of the member;

2.2.11.2.3. Services provided through the Dental Plan, date of service, service site, and name of service provider;

2.2.11.2.4. Medical and Dental history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the Dental Plan;

2.2.11.2.5. Referrals including follow-up and outcome of referrals;

2.2.11.2.6. Documentation of emergency and/or after-hours encounters and follow-up;

2.2.11.2.7. Signed and dated consent forms (as applicable);

2.2.11.2.8. Documentation of each visit which must include:

2.2.11.2.8.1. Dates of service;

2.2.11.2.8.2. Chief complaint or purpose of the visit;

2.2.11.2.8.3. Diagnoses;

2.2.11.2.8.4. Objective findings;

2.2.11.2.8.5. Patient assessment findings;

2.2.11.2.8.6. Studies ordered and results of those studies (e.g. laboratory, x-ray,);

2.2.11.2.8.7. Medications prescribed;

2.2.11.2.8.8. Oral health education provided;

2.2.11.2.8.9. Name and credentials of the provider rendering services (e.g. DDS, DMD,) and the signature or initials of the provider; and

2.2.11.2.8.10. Initials of providers must be identified with correlating signatures.

2.2.11.3. The Dental Plan is required annually to provide one (1) free copy to the member of any part of their record upon member's request.

2.2.11.4. All documentation and/or records maintained by the Dental Plan and its providers shall be maintained for at least six (6) years after the last good, service or supply has been provided unless those records are subject to review, audit, for investigations or subject to an administrative or judicial action brought by or on behalf of the state or federal government.

2.2.11.5. The Dental Plan and its providers shall participate in DHH's endeavor to move toward electronic health records.

2.2.12. Confidentiality of Medical Records

2.2.12.1. The Dental Plan shall have in place policies and procedures to ensure the confidentiality of Medical Records in accordance with 42 CFR 438.224 and 45 CFR Parts 160 and 164 subparts A and E. Each member shall be required to sign a HIPAA release form annually.

2.2.13. Quality

2.2.13.1. The Dental Plan shall develop improvement/quality assurance processes that are based on professional standards and ethics to maintain meaningful results. The following approach may include, but not be limited to:

2.2.13.1.1. Collect, compile and analyze data;

2.2.13.1.2. Conduct independent evaluation of oral health programs;

2.2.13.1.3. Develop and test innovative models of care through demonstration and pilot projects; and

2.2.13.1.4. Communicate oral health issues.

2.2.13.2. The Dental Plan shall support practitioners, insurers, policy makers, advocates, and consumers in making thoughtful decisions about oral health care.

2.2.13.3. Internal Quality Controls

2.2.13.3.1. The Dental Plan shall create staff training, policy and procedures with internal quality control for monitoring.

2.2.13.3.1.1. Training Regimen for Customer Service Staff – Must outline:

- **A.** Skill and experience level of trainers
- **B.** Content of training
- **C.** Length of training
- **D.** Frequency of training
- **E.** Training test/evaluation
- **F.** Refresher training requirements/intervals

2.2.13.3.1.2. Training Regimen for Customer Service Staff – Must outline:

- **A.** Skill and experience level of trainers
- **B.** Content of training
- **C.** Length of training
- **D.** Frequency of training
- **E.** Training test/evaluation
- **F.** Refresher training requirements/intervals

2.2.13.3.1.3. Automated System for Client Contacts -Must Outline:

- **A.** How inquiries received and tracked
- **B.** How content of inquiries is documented
- **C.** Process for how issue is addressed

2.2.13.3.1.4. Automated System for Client Calls -Must Outline

- **A.** How calls are received and logged
- **B.** Routing procedure if the representative cannot handle
- **C.** Process for call routing when necessary
- **D.** Interactive Voice Response (IVR) protocol

2.2.13.4. Quality Improvements/HEDIS Measures

	Quality Improvement Measures
1.	Percentage of enrollees reporting satisfaction with LAP dental coverage and services
2.	Pay 98% of claims in 30 days.
3.	Answer 80% of calls within 30 seconds.
4	Maintain a call abandonment rate of no more than 7%.
5	Process all appeals requests within 30 days.

HEDIS Measure
Total number of LAP eligible who have annual dental exams

2.2.13.4.1. The Dental Plan shall ensure that all utilization staff will have 100% of their determinations audited until their performance is 95% accurate. Utilization staff shall maintain 95% accuracy in their determinations.

2.2.13.4.2. The Dental Plan must track new performance measures that are approved by the secretary of the United States Department of Health & Human Services during the contract period.

2.2.14. <u>Complaints and Appeals</u>

2.2.14.1. General

2.2.14.1.1. The Dental Plan must provide DHH with a copy of its Complaints and Appeals Plan. DHH must authorize the Dental Plan's use of its policies and procedures for complaints and appeals and to construe and interpret the terms of the Plan Document subject to DHH's retention of full responsibility as Plan Administrator. LaCHIP Affordable Plan members/families may appeal a claims denial to the Dental Plan in accordance with the plan document's provisions. DHH

reserves the right to make final claims decisions on complaints and appeals involving LaCHIP Affordable Plan members and dental providers.

2.2.14.1.2. The Dental Plan must maintain an electronic system for tracking all complaints and appeals. The Dental Plan's system must record who lodged the complaint or appeal, the recipient involved, the number of contacts made, the information received, and the outcome.

2.2.14.1.3. The Dental Plan will report all member and provider complaints and appeals to DHH on a weekly basis. LaCHIP Affordable Plan members or their families, on their behalf, may appeal denied service requests and denied claims to the Dental Plan in accordance with the plan document's provisions.

2.2.14.2. Member

2.2.14.2.1. An appeal is a result of a member's disagreement with a decision of service request or the denial of a claim.

2.2.14.2.2. A complaint can be any issue other than an appeal. A complaint can be lodged against the Dental Plan or providers in the network.

2.2.14.2.3. The Dental Plan must allow members to appeal denied service requests and denied claims.

2.2.14.2.4. The Dental Plan must allow members to lodge a complaint against the Plan, or its providers.

2.2.14.3. Providers

2.2.14.3.1. The Dental Plan must allow the providers to appeal any claims denials.

2.2.14.3.2. The Dental Plan must allow providers to file complaints regarding the Dental Plan or LaCHIP Affordable plan members.

2.2.15. Outreach and Education (Members)

2.2.15.1. All Member outreach and education materials must comply with the following:

2.2.15.1.1. Be available in English, Spanish and Vietnamese.

2.2.15.1.2. Be approved by DHH in writing prior to distribution (includes all revisions to previously approved documents).

2.2.15.1.3. Be written on a 5th (fifth) grade level.

2.2.15.2. Orientation Packet

2.2.15.2.1. Each new member will receive an orientation packet from the Dental Plan within ten (10) business days of the receipt of enrollment files. The orientation packet includes the following:

2.2.15.2.1.1. Welcome Letter,
2.2.15.2.1.2. Member Identification Card,
2.2.15.2.1.3. Member Handbook,
2.2.15.2.1.4. Provider Directory,
2.2.15.2.1.5. Personalized Provider Directory,
2.2.15.2.1.6. Educational Brochure, and
2.2.15.2.1.7. Notice of Privacy Practice.

2.2.15.2.2. The Dental Plan will design, print and distribute the orientation packet in compliance with RFP requirements.

2.2.15.3. Welcome Letter

2.2.15.3.1. The welcome letter congratulates the new member for participating in the program and outlines the materials contained in the orientation packet.

2.2.15.4. Member Identification Card

2.2.15.4.1. The member identification card shall be a sturdy, plastic, peel-off segment of the welcome letter. The card shall contain the

member's name; the Dental Plan's name, toll-free telephone number and Web site; and the effective date of coverage.

2.2.15.5. Member Handbook

2.2.15.5.1. The handbook shall include, but is not limited to, the following sections:

2.2.15.5.1.1. *Introduction*
Welcomes the member to the dental plan. Explains how to use the handbook. Explains the relationship between the Dental Plan, the LaCHIP Affordable Plan and the member. Lists the Dental Plan's toll-free Call Center telephone number with a statement that the member may contact the Plan for help locating a dentist or obtaining appointment assistance or to answer any other questions.

2.2.15.5.1.2. *Definitions*
This section shall be a list of words and terms to help the member understand the content of the handbook.

2.2.15.5.1.3. *Member Rights and Responsibilities*
This section shall describe member rights and responsibilities when accessing services under the Plan. This may include information regarding co-pays and service requests.

2.2.15.5.1.4. *Accessing Care*
This section shall discuss physical access and access for the hearing and vision impaired; as well as assistance for those members whose primary language is not English.

2.2.15.5.1.5. *Using the Dental Plan*
This section shall explain how to choose a dentist, how to schedule appointments, how to obtain emergency and urgent dental care services and related topics, and also explains members' cost-sharing responsibilities.

2.2.15.5.1.6. *Schedule for Dental Care*

This section shall provide a list of covered services and the periodicity in which they should be received.

2.2.15.5.1.7. *Coordination of Services*
This section shall identify any agencies/entities whose dental services and benefits may be available to members.

2.2.15.5.1.8. *Excluded Services*
This section shall list the dental benefits that are not covered by the Plan.

2.2.15.5.1.9. *Complaints and Appeals Process*
This section shall describe how to file a complaint and/or appeal, including the roles of the Dental Plan and DHH in that process.

2.2.15.6. Provider Directory

2.2.15.6.1. The LaCHIP provider directory shall list the Dental Plan's network of dentists. The directory shall be sorted by region, specialty and for each office location, shall include the provider name, address, telephone numbers, office hours, languages spoken and specialties.

2.2.15.7. Personalized provider directories

2.2.15.7.1. This shall be an abridged provider listing highlighting the dentists closest to the member's home. This makes it easier for members to choose a dentist versus having to review a comprehensive listing of dentists throughout the state.

2.2.15.8. Educational Brochure

2.2.15.8.1. This brochure shall explain the importance of visiting the dentist regularly and the proper way to brush and floss teeth.

2.2.15.9. Notice of Privacy Practices

2.2.15.9.1. This notice shall describe how medical and dental information about each member is protected and how this

information may be used by the Dental Plan. It shall also inform the member of his or her rights regarding personal health information and how to contact the Dental Plan with questions or concerns about this notice.

2.2.15.10. Educational Materials

2.2.15.10.1. The Dental Plan must distribute general dental health educational materials to plan participants and the general public. This may be in the form of letters, postcards, brochures, flyers, posters, coloring books or fact sheets. The purpose of the materials is to promote good dental health, oral hygiene and/or encourage preventive measures.

2.2.15.10.2. New educational materials must be made available to members, at a minimum, on a monthly basis. Educational materials can include those items designed by the plan or some other qualified entity. All materials, including those from other entities, must be reviewed and approved by DHH before distribution.

2.2.15.10.3. Distribution of materials must include posting to the Web site. Dental Plans may also choose to mail directly to members or distribute in community/common areas (community centers, Medicaid offices, school based health clinics, dental offices, etc.). At a minimum, four of the 12 items must be mailed directly to members.

2.2.15.11. Community Outreach

2.2.15.11.1. The Dental Plan shall engage in disease prevention and health promotion campaigns and programs that affect oral and general health including collaborations with public health and health care practicing communities. The Dental Plan shall partner with communities to help ensure members' optimal access to high-quality care. The following types of essential partnerships include, but are not limited to:

2.2.15.11.1.1. Federally Qualified Health Centers (FQHCs),
2.2.15.11.1.2. Rural Health Centers (RHCs),

2.2.15.11.1.3. School Based Health Centers (SBHCs),
2.2.15.11.1.4. Private Practice Dentists,
2.2.15.11.1.5. Health Fairs,
2.2.15.11.1.6. Head Start Programs,
2.2.15.11.1.7. Women Infant and Children (WIC) nutritional programs,
2.2.15.11.1.8. Faith-Based initiatives,
2.2.15.11.1.9. Ethnic/Cultural Initiatives,
2.2.15.11.1.10. Public Awareness Campaigns,
2.2.15.11.1.11. Other Oral Health Programs, and
2.2.15.11.1.12. State Universities.

2.2.15.11.2. The Dental Plan shall have a presence at a minimum of two events per year. The Dental Plan must notify DHH of all community event participation, but prior approval is not required. Some examples of appropriate community events would include Medicaid-sponsored health fairs; faith-based activities; school-based or community-sponsored health fairs.

2.2.16. Provider Training and Support

2.2.16.1. For all new and any interested providers, the Dental Plan shall conduct one-on-one training sessions, webinars, or telephonic training seminars. These training sessions should employ PowerPoint presentations and other interactive methods to disseminate critical program information.

2.2.16.2. Providers shall receive information on topics including:

2.2.16.2.1. Dental practice management,

2.2.16.2.2. Claim form completion,

2.2.16.2.3. Electronic billing,

2.2.16.2.4. Dental best practices,

2.2.16.2.5. Information and practice guidelines for delivering preventive health services consistent with ADA and AAPD recommendations regarding the periodicity of professional dental services for children, EPSDT program requirements, and the delivery of EPSDT services,

2.2.16.2.6. Identification and reporting of suspected fraud and abuse involving member or other dental providers,

2.2.16.2.7. Medicaid dental covered services,

2.2.16.2.8. Utilization management,

2.2.16.2.9. Pre-certification,

2.2.16.2.10. Technology and dentistry, and

2.2.16.2.11. Any other information that would be helpful to dental providers in providing dental covered services to members.

2.2.16.3. Contractor's representatives shall visit newly contracted dentists. Such visits may include structural reviews, which cover a variety of topics, including patient accessibility, facility and equipment conditions, emergency procedures and equipment, sterilization and infection control procedures and equipment, radiology procedures and equipment and office administration. The visit also ensures that providers and their office staff have the materials and information they need to successfully participate in the network and render dental care to members.

2.2.16.4. Other provider outreach and education services conducted by the Dental Plan must include, but are not limited to, the following:

2.2.16.4.1. Monitoring reports that identify providers experiencing unusually high rates of claims problems with the goal of resolving administrative issues;

2.2.16.4.2. Visiting providers who have new staff or questions regarding the Dental Plan or customer policies;

2.2.16.4.3. Conducting unscheduled visits to providers in conjunction with other appointments in the area;

2.2.16.4.4. Conducting visits to providers based on referrals from other Dental Plan staff, the customer, members or providers; and

2.2.16.4.5. Distributing a quarterly bulletin to providers that includes current topics and educational articles.

2.2.16.5. Annually, the Dental Plan shall conduct provider seminars in locations convenient for the Dental Plan network providers and their office staff. These informative seminars review administrative policies and procedures for billing, as well as plan goals and information. The Dental Plan shall provide a variety of educational information on the Dental Plan's website.

2.2.17. Utilization Management

2.2.17.1. Pre-Certification procedures

2.2.17.1.1. The Dental Plan shall balance the need for pre-certification of select services with minimizing administrative burdens on providers and eliminating barriers to patient care. The Dental Plan must develop a pre-certification policies and procedure plan. Prior to implementation of the contract, the Dental Plan must submit a copy of the Pre-certification Plan for approval to DHH.

2.2.17.1.2. Pre-certification requests must be processed within 10 business days of receipt of the request. Once a decision is rendered, notification of the decision must be mailed to the provider and the member.

2.2.17.1.3. The Dental Plan must have the ability to electronically maintain all pre-certification approvals and denials. Once the request is entered into the pre-certification system, a permanent file shall be created. All captured data elements shall be available for reporting and to DHH upon request.

2.2.17.1.4. The Dental Plan shall accept pre-certification requests from dental providers in a variety of submission methods including paper, fax, and US mail, online website, and utilizing HIPAA standard EDI transactions (i.e., 834) uploaded to secure portal. The plan must include procedures to allow providers to submit documentation/attachments to electronically submitted requests.

2.2.18. Claims Management

2.2.18.1. General Provisions

2.2.18.1.1. The Dental Plan must process the provider's claims for covered services provided to members, according to

provisions identified in this RFP including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.

2.2.18.2. Claims System

2.2.18.2.1. The Dental Plan shall:

2.2.18.2.1.1. Maintain a claims management system that will include:

A. Data that uniquely identifies the attending and billing provider of each service,

B. Date of receipt of claims,

C. Real-time accurate history to include dates of result of the adjudication for each provider claim such as paid, denied, suspended, appealed, etc., and follow up information on appeals

D. Payment method to include:

- Form of payment, i.e. electronic funds transfer (EFT), or check,
- The date of payment and check number if applicable, and
- Payment amount.

2.2.18.2.1.2. Have in place, an electronic claims management (ECM) capability that accepts and processes claims submitted electronically.

2.2.18.2.1.3. Ensure the ECM capability shall function in accordance with information exchange and data management requirements as specified in Section2.2.24–TECHNICAL REQUIREMENTS of this RFP.

2.2.18.2.1.4. Ensure that as part of the ECM function; provide on-line and phone-based capabilities to obtain processing status information.

2.2.18.2.1.5. Support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments.

2.2.18.2.1.6. Not derive financial gain from a provider's use of electronic claims filing functionality and/or services

offered by the Dental Plan or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.

2.2.18.3. Claims Formats

2.2.18.3.1. Beginning the first day of operations, the Dental Plan's System shall conform to HIPAA-compliant (i.e. 834) standards for information exchange. Transaction types are subject to change and the Dental Plan shall comply with applicable federal and HIPAA standards and regulations as they occur.

2.2.18.3.2. The Dental Plan shall comply at all times with nationally recognized dental claim forms, and future updates. The Dental Plan shall not revise or modify the standardized forms or format.

2.2.18.3.3. The Dental Plan shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federally required safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

2.2.18.3.4. The Dental Plan agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the Dental Plan shall comply with said recommendations within ninety (90) calendar days from notice by DHH.

2.2.18.4. Prompt Payment to Providers

2.2.18.4.1. The Dental Plan shall:

2.2.18.4.1.1. Comply with Louisiana's claims payment regulations found in LA. R.S. 22:1831-1838.

2.2.18.4.1.2. If a claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, appropriate written or electronic notice shall specifically identify all such information and documentation. Resubmission of a claim

with further information and/or documentation shall constitute a new claim for purposes of establishing the time frame for claims processing.

2.2.18.5. Claims Processing Methodology Requirements

2.2.18.5.1. The Dental Plan shall perform front end system edits, including, but not limited to:

2.2.18.5.1.1. Determine whether a covered service required per-certification and if so, whether the Dental Plan granted such approval;

2.2.18.5.1.2. Flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;

2.2.18.5.1.3. Verify whether or not a service is a covered service;

2.2.18.5.1.4. Approve for payment only those claims received from providers eligible to render service for which the claim was submitted;

2.2.18.5.1.5. Evaluate claims for services provided to members to ensure that any applicable benefit limits are applied; and

2.2.18.5.1.6. Ensure that benefit limit rules set by the Dental Plan's approved benefit package are factored into the determination of whether a claim should be adjudicated and paid.

2.2.18.5.1.7. Perform system edits for valid dates of service, and assure that dates of service are valid dates to coincide with member's dates of eligibility.

2.2.18.5.1.8. Perform post-payment review on a sample of claims to ensure services provided were medically necessary; and have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.

2.2.18.6. Explanation of Benefits (EOBs) and Related Functions

2.2.18.6.1. The Dental Plan shall:

2.2.18.6.1.1. Be responsible for generating and mailing EOBs to members in accordance with Dental Plan established guidelines, which shall be approved by DHH.

2.2.18.6.1.2. At a minimum, design EOBs to address requirements found in 42 CFR 455.20 and 433.116 as well as requirements associated with a change in DHH policy and shall include claims for services with benefit limits, claims with member cost sharing, denied claims with member responsibility, and a sampling of paid claims.

2.2.18.6.1.3. Stratify paid claims to ensure that all provider types (or specialties) are represented in the pool of generated EOBs. To the extent that the Dental Plan considers a particular specialty (or provider) to warrant closer scrutiny, the Dental Plan may over sample the group. The paid claims sample should be a minimum of twenty-five (25) claims per check run with a minimum of 100 claims per month.

2.2.18.7. Remittance Advices and Related Functions

2.2.18.7.1. In conjunction with its payment cycles, the Dental Plan shall provide:

2.2.18.7.1.1. An electronic status report indicating the disposition for every adjudicated claim for each claim type submitted by providers seeking payment. The status report shall contain appropriate explanatory remarks related to payment or denial of the claim.

2.2.18.7.1.2. If the claim is partially or totally denied on the basis the provider did not submit any required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation.

2.2.18.7.1.3. In accordance with 42 CFR 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: " I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents,

or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."

2.2.18.8. Processing of Payment Errors

2.2.18.8.1. The Dental Plan shall not employ off-system or gross adjustments when processing corrections to payment errors, unless it requests and receives prior written authorization from DHH.

2.2.18.9. Notification to Providers

2.2.18.9.1. For purposes of network management, the Dental Plan shall, notify all contracted providers to file claims associated with covered services directly with the Dental Plan or its subcontractors, on behalf of LaCHIP Affordable Plan members.

2.2.18.10. Provider Payment Cycles

2.2.18.10.1. At a minimum, the Dental Plan shall run one (1) provider payment cycle per week, on the same day each week, as determined by the Dental Plan and approved by DHH.

2.2.18.11. Excluded Providers

2.2.18.11.1. The Dental Plan shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or SCHIP pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise under investigation for fraud or abuse by the State of Louisiana.

2.2.19. <u>Fraud and Abuse</u>

2.2.19.1. The Dental Plan shall have internal controls and policies and procedures in place that are designed to prevent, detect, and report known or suspected fraud and abuse activities. Such policies and procedures must be in accordance with Federal regulations described in 42 CFR Parts 455 and 456.

2.2.19.2. The Dental Plan shall have adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist the Dental Plan in preventing and detecting potential fraud and abuse activities.

2.2.20. Reporting Requirements

2.2.20.1. Reports defined and approved by DHH to be generated by the Dental Plan shall meet all state and federal reporting requirements. The needs of DHH and other appropriate agencies for planning, monitoring and evaluation shall be taken into account when developing report formats and compiling data. The Dental Plan may also be asked to produce a minimum of twelve (12) ad-hoc reports in cooperation with other federal and/or state agencies upon request of DHH, and at no additional cost to DHH.

2.2.20.2. The Dental Plan shall submit monthly reports by the tenth (10th) calendar day of the month following the reporting month. Any weekly reports shall be submitted by the Wednesday following the end of the reporting week. Reports to be generated are not limited to those listed below and may include additional categories as required for state and federal reports or as described in the Scope of Work, at no additional cost to DHH.

2.2.21. Programmatic Reports

2.2.21.1. Staffing

2.2.21.1.1. *Staffing Level Report*

2.2.21.1.1.1. The Dental Plan shall report a quarterly listing of staff working with this contract. The report must show that the Dental Plan employs dental and professional support staff sufficient to conduct daily business in an orderly manner including having member services staff directly available during business hours for member services consultations, as determined through management and dental reviews.

2.2.21.2. Criminal Background Check Report

2.2.21.2.1. All temporary, permanent, subcontracted, part-time and full-time Dental Plan staff working on Louisiana Medicaid contracts must have a national criminal background check prior to starting work on the contract. The results shall include

all felony convictions and shall be submitted to DHH for review prior to the start of work on the contract and before any subsequent new employees begin work on this contract.

2.2.21.3. Ineligible Persons Report

2.2.21.3.1. All temporary, permanent, subcontract, part-time and full-time Dental Plan staff working on Louisiana Medicaid contracts must complete an annual statement that includes an acknowledgement of confidentiality requirements and a declaration as to whether the individual has been convicted of a felony crime or has been determined an “Ineligible Person” to participate in Federal healthcare programs or in Federal procurement or non-procurement programs.

2.2.21.3.2. The Dental Plan shall keep the individual statements on file and submit a comprehensive list of all current staff in an annual statement to DHH, indicating if the staff stated they were free of convictions or ineligibility referenced above.

2.2.21.4. Toll-Free Call Center

2.2.21.4.1. The Dental Plan, through an ACD system, shall generate reports with statistics on all incoming calls, including the amount of time that a call has been holding, and the number of busy signals, and/or abandoned calls in the system. The Dental Plan shall submit reports to DHH upon request, including information pertaining to individual calls. The Dental Plan shall analyze the reports and make appropriate adjustments to call center resources.

2.2.21.5. Enrolled Providers

2.2.21.5.1. The Dental Plan shall report all enrolled providers, their locations, and office hours to DHH at the onset of the contract. The Dental Plan shall update DHH monthly on new providers and providers who are no longer participating in the Dental Plan. The Dental Plan must submit, along with this report, information indicating that the providers were credential before the Dental Plan contracted with them. The Dental Plan shall submit the same information every two (2) years indicating

that providers have been re-credentialed according to this RFP.

2.2.21.6. Quality

2.2.21.6.1. *Quality Improvement Measures*

2.2.21.6.1.1. The Dental Plan shall report all Quality Improvement Measures required in this RFP to DHH monthly and shall have documentation to back up these reports.

2.2.21.6.2. *HEDIS Measure*

2.2.21.6.2.1. The Dental Plan shall report the HEDIS measures on quarterly basis.

2.2.21.6.3. *New Performance Measures*

2.2.21.6.3.1. The Dental Plan must report any new performance measures that are approved by the secretary of the United States Department of Health & Human Services during the contract period. The timelines for any such reports will be dictated by the state at the time the new performance measures are approved by the Secretary of the United States Department of Health & Human Services.

2.2.21.7. Utilization Report

2.2.21.7.1. The Dental Plan must report monthly the utilization staff's accuracy in their determinations.

2.2.21.8. Complaints and Appeals

2.2.21.8.1. The Dental Plan shall report all member and provider complaints, appeals, and resolutions to DHH on a weekly basis. This report shall include the date of the complaint or appeal, name of the member, issue, and the date of the resolution.

2.2.21.9. Outreach and Orientation

2.2.21.9.1. The Dental Plan shall report monthly the number of orientation packets mailed. The Dental Plan shall notify DHH in advance of any community outreach. The Dental Plan shall monthly report to DHH any provider training that took place in the previous month.

2.2.21.10. Pre-certification

2.2.21.10.1. The Dental Plan shall monthly report to DHH the number of pre-certification request received, the date that a decision was made on each request, and the date the notification was mailed.

2.2.22. Contract Management Requirements

2.2.22.1. The Dental Plan shall electronically submit all required procedures, and written material sixty (60) days after the start of the contract for approval by DHH. DHH shall review for approval over all manuals, policies, and procedures related to this RFP.

2.2.22.2. The Contract Monitor must be notified at least two (2) weeks in advance of all scheduled meetings.

2.2.23. Technical Requirements

2.2.23.1. Information Technology

2.2.23.1.1. The Dental Plan must accept from DHH a daily electronic eligibility data though a secured file which contains:

2.2.23.1.1.1. Addition (closure) of a member;

2.2.23.1.1.2. Changes to the Person's SSN, First Name, Last Name, Middle Initial, Birth Date, Gender, Address (including City, State and Zip Code) and Phone number;

2.2.23.1.1.3. Changes to the family's gross income;

2.2.23.1.1.4. Changes to a renewal date (eligibility start date); and

2.2.23.1.1.5. Effective and termination dates as applicable.

2.2.23.1.2. The eligibility start date should always be the beginning of the following month, along with the premium amount ($50 or zero if American Indian/Native Alaskan). DHH is responsible for sending the approval notice to the member, along with the initial DHH billing notice, all subsequent billing notices are the responsibility of LaCHIP Affordable Plan Contractor. The following day, LaCHIP Affordable Plan Contractor will return an electronic file to DHH which contains a Member ID for the household. This file will be stored in the DHH MEDS system.

2.2.23.1.3. The Dental Plan's system must be capable of accepting from DHH a daily electronic file containing information DHH receives from LaCHIP Affordable Plan Contractor. The Dental Plan's system shall be able to read, maintain, track and update all data elements provided in the file format. This process shall be system-supported, not a manual function. The Dental Plan will receive daily files from DHH and must be capable of transmitting daily out of pocket expenses (co-pay) files to the LaCHIP Affordable Plan Contractor in a file format as specified by them. A specific timeframe will be determined by DHH. The Dental Plan shall convert and apply transmitted data to their eligibility and claims system for purposes of claims payments within two (2) business day of receipt of a successful transmission.

2.2.23.1.4. Once the member pays their first premium to LaCHIP Affordable Plan Contractor, LaCHIP Affordable Plan Contractor will initiate mailing of their benefit package and ID cards to the member so that they may access benefits. When the Dental Plan receives this information in the data file, it shall provide the member with an Orientation Packet to include information identified in the RFP.

2.2.23.1.5. If a premium is not collected by LaCHIP Affordable Plan Contractor by the 6th of the month, that contractor provides a non-payment file to DHH, and DHH sends an automated adverse action notice to the member notifying them that benefits will cease as of the end of the current month unless

premium is paid. A pending and expected closure date is set on the data file. LaCHIP Affordable Plan Contractor sends DHH an electronic file starting on the next working day up to the 4th to last working day of the month (cutoff) notifying DHH of those members who did not pay their premium. For those members, DHH will automatically close their case at cutoff for that month and this information will be reflected in the daily file to both LaCHIP Affordable Plan Contractor and the Dental Plan.

2.2.23.1.6. The MEDS system will calculate the family's gross annual household income to determine the cap amount for each enrollment period (5%). This amount will be provided to the household in the original approval notice. This amount will also be provided to LaCHIP Affordable Plan contractor and the Dental Plan in the daily files, as both will be collecting claims payment amounts. The LaCHIP Affordable Plan Contractor's system will track the family's payments, including Dental Plan co-pays, on a daily basis to determine when the family has met the cap. Once this happens, the family is no longer responsible for payment of either the premium or claim co-payments.

2.2.23.1.7. If during the member's eligibility period a new cap amount is set, DHH will send a new enrollment period on the electronic file.

2.2.23.1.8. The Dental Plan shall establish and maintain a single, uniform system to update eligibility records for members. This system shall accept eligibility data from DHH in accordance with its standard eligibility protocols through an online electronic transfer, perform eligibility file matches, and identify and advise DHH of discrepancies.

2.2.23.1.9. The Dental Plan shall notify DHH by 12:00 p.m. of the day following an unsuccessful transmission so that DHH can reschedule the transmission. Each year the Dental Plan shall submit a schedule to DHH outlining the days that the Dental Plan will be unable to accept a transmission. In the event of any discrepancies, the Dental Plan shall notify DHH. The

transmitted data (data not requiring additional follow up or investigation) shall be converted and applied to the Dental Plan's claims system for purposes of claims payment within two (2) business days of receipt of a successful transmission. The two (2) business day deadline shall not apply during annual enrollment or file match periods, although the Dental Plan shall convert and apply the transmitted data to its claims system as soon as possible.

2.2.23.2. Eligibility Closure

2.2.23.2.1. The Dental Plan shall convert and apply to its claims system all eligibility closure codes sent by DHH as part of the daily eligibility transmission.

2.2.23.3. General Information Technology Requirements

2.2.23.3.1. The Dental Plan's information system must have and maintain capacity sufficient to handle the workload projected for the begin date of operations. The system also must be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the contract requirements.

2.2.23.3.2. The Dental Plan must maintain a continuously available electronic mail communication system to facilitate communication with DHH. This system must be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office Outlook and any subsequent upgrades as adopted. The Dental Plan must comply with national standards for submitting public health information (PHI) electronically.

2.2.23.3.3. The Dental Plan's system must be able to transmit, receive and process data in DHH-specific formats and/or methods that are in use on the contract execution date, and as the DHH's technology advances.

2.2.23.3.4. The Dental Plan shall:

2.2.23.3.4.1. Be responsible for acquiring and maintaining necessary hardware, software, and network resources to support the requirements of this RFP;

2.2.23.3.4.2. Adhere to all state and federal regulations and guidelines, as well as industry standards and best practices, for information systems, data exchange, and any functions necessary to fulfill the requirements of this RFP;

2.2.23.3.4.3. Be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the Dental Plan's system(s). These costs include, but are not limited to, hardware, software, licensing, licensing certificates, public address, authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH;

2.2.23.3.4.4. Identify in their proposal all systems which are considered to be proprietary;

2.2.23.3.4.5. Have the capability to securely transfer or exchange data with DHH, in the requested formats, within the timelines approved by DHH and specified in this RFP. The Dental Plan shall have the capability to interface with existing and future systems, comply with Section 508 of the Rehabilitation Act of 1973 with regards to any websites exposed to the public. DHH will maintain ownership rights to all Internet registered domains for all websites exposed to the public;

2.2.23.3.4.6. Develop, test and maintain a Disaster Recovery and Business Continuity Plan (DR/BCP) and procedures to allow them to continue to deliver essential business functions despite damage, loss or disruption of information technology due to the unexpected occurrence of a natural or man-made emergency or disaster;

2.2.23.3.4.7. Submit the DR/BCP to DHH for approval at prior to implementation date. The plans should include: Risk Assessment, Business Impact Analysis, Alignment to Business Strategy, Alignment to Business Continuity Strategy, and Testing and Updating Plans;

2.2.23.3.4.8. Provide online documentation of the system(s) to be delivered upon implementation, within thirty (30) days of a major change, or as requested by DHH;

2.2.23.3.4.9. Ensure the system(s) will be available twenty-four (24) hours, seven (7) days a week. Maintenance and down time shall be scheduled and approved by DHH. All unscheduled downtime must be reported to DHH immediately, with stated corrective action and workarounds;

2.2.23.3.4.10. Provide DHH staff with real time access to the system(s) and shall incur all of the related costs; and

2.2.23.3.4.11. Submit a transition/takeover plan which outlines the procedures and timelines to ensure continuity of services in the event of contract termination or award of contract to another vendor. The transition/takeover plan must include procedures that shall, at a minimum, comply with the following stipulations:

A. Upon completion of the contract or if terminated earlier, all records, reports, work sheets or any other pertinent materials related to the execution of the contract shall become the property of DHH;

B. In the event of contract termination, or as requested, the Dental Plan shall transfer all data and non-proprietary systems to DHH or new vendor within the agreed upon time frame;

C. Upon termination of the contracted services, all equipment purchased under this agreement shall revert to DHH. The Dental Plan agrees to deliver any such

equipment to DHH within the pre-determined time frame; and

D. The transition/takeover plan must be adhered to within thirty (30) calendar days of written notification of contract termination, unless other appropriate time frames have been mutually agreed upon by both the Dental Plan and DHH.

2.2.23.3.5. ***Data Access***

2.2.23.3.5.1. Medicaid will have read-only access to any front end systems which are involved in the process.

2.2.23.3.5.2. Medicaid reserves the right to request regular data transfers of any of the information in systems owned by the Dental Plan. Methods used for these data transfers shall include encrypted secure public FTP, web services, or any other method which has been deemed efficient and secure by industry standards.

2.2.23.3.5.3. In the event of contract termination, or as requested, the Dental Plan shall transfer all data back to DHH.

2.2.24. Subcontracting Requirements

2.2.24.1. The Dental Plan shall not contract with any other party for furnishing any of the work and professional services required by the contract without the express prior written approval of DHH. The Dental Plan shall not substitute any subcontractor without the prior written approval of DHH. For subcontractor(s), before commencing work, the Dental Plan will provide letters of agreement, contracts or other forms of commitment which demonstrates that all requirements pertaining to the proposal will be satisfied by all subcontractors through the following:

2.2.24.1.1. The subcontractor(s) shall provide a written commitment to accept all contract provisions.

2.2.24.1.2. The subcontractor(s) shall provide a written commitment to adhere to an established system of accounting and financial controls adequate to permit the effective administration of the contract.

2.2.25. Insurance Requirements

2.2.25.1. Insurance shall be placed with insurers with an A.M. Best's rating of no less than A-VI. This rating requirement shall be waived for Worker's Compensation coverage only.

2.2.25.1.1. ***Dental Plan's Insurance***

The Dental Plan shall not commence work under this contract until it has obtained all insurance required herein. Certificates of Insurance, fully executed by officers of the insurance company shall be filed with DHH for approval. The Dental Plan shall not allow any subcontractor to commence work on subcontract until all similar insurance required for the subcontractor has been obtained and approved. If so requested, the Dental Plan shall also submit copies of insurance policies for inspection and approval of DHH before work is commenced. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days written notice in advance to DHH and consented to by DHH in writing and the policies shall so provide.

2.2.25.1.2. ***Compensation Insurance***

Before any work is commenced, the Dental Plan shall obtain and maintain during the life of the contract, Workers' Compensation Insurance for all of the Dental Plan's employees currently employed to provide services under the contract. In case any work is sublet, the Dental Plan shall require the subcontractor similarly to provide Workers' Compensation Insurance for all the latter's employees, unless such employees are covered by the protection afforded by the Dental Plan. In case any class of employees engaged in work under the contract at the site of the project is not protected under the Workers' Compensation Statute, the Dental Plan shall provide for any such employees, and shall further provide or cause any and all subcontractors to provide Employer's

Liability Insurance for the protection of such employees not protected by the Workers' Compensation Statute.

2.2.25.1.3. ***Commercial General Liability Insurance***

The Dental Plan shall maintain during the life of the contract such Commercial General Liability Insurance which shall protect Dental Plan, DHH, and any subcontractor during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as for claims for property damages, which may arise from operations under the contract, whether such operations be by the Dental Plan or by a subcontractor, or by anyone directly or indirectly employed by either of them, or in such a manner as to impose liability to DHH. Such insurance shall name DHH as additional insured for claims arising from or as the result of the operations of the Dental Plan or its subcontractors. In the absence of specific regulations, the amount of coverage shall be as follows: Commercial General Liability Insurance, including bodily injury, property damage and contractual liability, with combined single limits of $1,000,000.

2.2.25.1.4. ***Licensed and Non-Licensed Motor Vehicles***

The Dental Plan shall maintain during the life of the contract, Automobile Liability Insurance in an amount not less than combined single limits of $1,000,000 per occurrence for bodily injury/property damage. Such insurance shall cover the use of any non-licensed motor vehicles engaged in operations within the terms of the contract on the site of the work to be performed there under, unless such coverage is included in insurance elsewhere specified.

2.2.25.1.5. ***Subcontractor's Insurance***

The Dental Plan shall require that any and all subcontractors, which are not protected under the Dental Plan's own insurance policies, take and maintain insurance of the same nature and in the same amounts as required of the Dental Plan.

2.2.26. Resources Available to Dental Plan

2.2.26.1. DHH will have an assigned staff member who will be responsible for primary oversight of the contract. This individual will be available to meet as requested by DHH to discuss progress of activities and identified problems.

2.2.27. Contact Personnel

2.2.27.1. All work will be performed under the direct supervision of:

Stacy McQuillin, Medicaid Program Manager 2
Medical Vendor Administration
Department of Health and Hospitals
Bienville Building
628 North 4th St.
Baton Rouge, LA 70821
Phone: (337) 857-6115
Stacy.McQuillin@la.gov

2.2.28. Term of Contract

2.2.28.1. The contract shall commence on or near the date approximated in the Schedule of Events. The term of this contract is for a period of three (3) years. There may be a possible extension for an additional twenty-four (24) month period; however, all contracts extending beyond the original thirty-six (36) months must be approved by the Joint Legislative Committee on the Budget (JLCB). The continuation of this contract is contingent upon the appropriation of funds by the legislature to fulfill the requirements of the contract.

2.2.29. Payment

2.2.29.1. The Dental Plan will be paid prospectively on a Per Member Per Month (PMPM) basis. The payment will be calculated monthly utilizing the contracted rate based on the number of plan members according to age categories in the previous month.

2.2.29.2. The payment shall be processed on the first Tuesday of every month based on the number of members enrolled in the Dental Plan for the next month. Member enrollment is determined on the third to last working day of the month. For age group assignment purposes, age will be defined as of the beginning of the month for which the capitation payment is intended.

2.2.29.3. The Dental Plan must submit an invoice to DHH by the 5th of the month for reconciliation purposes. The payment made on the first Tuesday of the month will be adjusted as needed based on this file.

2.2.29.4. The Dental Plan shall accept all payments through an electronic funds transfer EFT. These funds will be transmitted into a mutually agreed upon bank account to be solely used for payment for the LaCHIP Affordable Plan Dental program.

2.2.29.5. The Dental Plan shall agree to accept payments as specified in this section and have written policies and procedures for receiving and processing PMPM payments and adjustments. Any charges or expenses imposed by the bank for transfers or related actions shall be borne by the Dental Plan.

2.2.29.6. No payment to the Dental Plan by DHH may be assigned by the Dental Plan. This does not prohibit the Dental Plan from arranging sub-prepaid payments to Dental Plan providers. This section shall not prohibit DHH at its sole option from making payment to a fiscal agent hired by the Dental Plan.

2.2.29.7. DHH will secure a retainage of 10% from all billings under the contract as surety for performance.

2.2.30. Department Payment Adjustments

2.2.30.1. In the event that an erroneous payment was made to the Dental Plan, DHH shall reconcile the error by adjusting the Dental Plan's next monthly PMPM payment.

2.2.30.2. The entire PMPM payment will be paid during the month of birth and month of death. No proration adjustment to payments will occur to reflect a partial month.

2.2.31. Liquidated Damages

2.2.31.1. In the event the Dental Plan fails to meet the performance standards specified within the contract, the liquidated damages defined below may be assessed. If assessed, the liquidated damages will be used to reduce DHH's payments to the Dental Plan or if the liquidated damages exceed amounts due from DHH, the Dental Plan will be required to make cash payments for the amount in excess, on notification from DHH. DHH reserves the right to utilize all available legal remedies.

2.2.31.1.1. Late submission of required reports: $50 per working day, per report.

2.2.31.1.2. Failure to fill vacant contractually required key staff positions within the initial sixty (60) days of contract: $500 per working day from the sixty-first (61st) day of vacancy until filled with an employee approved by DHH.

2.2.31.1.3. Failure to fill vacant contractually required key staff positions within forty-five (45) days of resignation announcement or vacancy: $250 per working day from the forty-sixth (46th) day of vacancy until filled with an employee approved by DHH.

2.2.31.1.4. Failure to comply with the corrective action plan within specified timelines of the Plan: $100 per working day after deadline for resolution.

2.2.31.1.5. Failure to meet performance standards laid out in this RFP will result in a fine of $ 100 a day until performance standards are met.

2.2.31.1.6. A complete systems or technical failure that prohibits data exchanges which exceeds 24 hours shall result in a fine of $500 per day of failure. This does not include scheduled systems shutdowns DHH is given prior notice of.

2.2.31.2. DHH's decision to impose a sanction may be based on an assessment of some or all of the following factors:

2.2.31.2.1. The duration of the violation (or one that is substantially similar) has previously occurred;

2.2.31.2.2. The Dental Plan's history of compliance;

2.2.31.2.3. The severity of the violation and whether it imposes an immediate threat to health or safety of the enrollees; and

2.2.31.2.4. The "good faith" exercised by the Dental Plan in attempting to stay in compliance.

3. PROPOSALS

3.1. GENERAL INFORMATION

3.1.1. This section outlines the provisions which govern determination of compliance of each Proposer's response to the RFP. DHH shall determine, at its sole discretion, whether or not the requirements have been reasonably met. Omissions of mandatory information shall be grounds for rejection of the proposal by DHH.

3.1.2. Proposals should address how the proposer intends to assume complete responsibility for timely performance of all contractual responsibilities in accordance with federal and state laws, regulations, policies, and procedures.

3.2. PROCUREMENT LIBRARY/RESOURCES AVAILABLE TO PROPOSER

3.2.1. Relevant material related to this RFP will be posted at the following web address: http://www.dhh.louisiana.gov/publications.asp?ID=1&CID=25 which will include the following documents related to this RFP:

3.2.1.1. DHH Regional Map including coverage estimates for each region;

3.2.1.2. CHIPRA Legislation http://www.cms.hhs.gov/chipra ; and

3.2.1.3. Federal Employees Health Benefit Plan Children's Dental Coverage http://www.federaldental.metlife.com

3.3. PROPOSAL SUBMISSION

3.3.1. All proposals must be received by the due date and time indicated on the Schedule of Events. Proposals received after the due date and time will not be considered. It is the sole responsibility of each Proposer to assure that its proposal is delivered at the specified location prior to the deadline. Proposals which, for any reason, are not so delivered will not be considered.

3.3.2. Proposer must submit one (1) original hard copy and should submit one (1) electronic copy and ten (10) hard copies of the proposal. In addition, a copy of the proposal should be submitted on either a compact disc (CD) or a digital video disc (DVD). No facsimile or emailed proposals will be

accepted. All proposal submissions should be clearly labeled DENTAL RFP. The cost proposal and financial statements should be submitted separately from the technical proposal; however for mailing purposes, all packages may be shipped in one container.

3.3.3. Proposals must be submitted via U.S mail, courier or hand delivered:

If courier mail or hand delivered:

Mary Gonzalez
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street 5th Floor
Baton Rouge, LA 70802

If delivered via U.S Mail:

Mary Gonzalez
Department of Health and Hospitals
Division of Contracts and Procurement Support
P.O Box 1526
Baton Rouge, LA 70821-1526

3.4. PROPRIETARY AND/OR CONFIDENTIAL INFORMATION

3.4.1. The designation of certain information as trade secrets and/or privileged or confidential proprietary information shall only apply to the technical portion of the proposal. The cost proposal will not be considered confidential under any circumstances. Any proposal copyrighted or marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

3.4.2. For the purposes of this RFP, the provisions of the Louisiana Public Records Act (La. R.S. 44.1 et. seq.) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFP shall be open to public inspection. Proposers are reminded that while trade secrets and other proprietary information submitted in conjunction with this RFP may not be subject to public disclosure, protections must be claimed by the proposer at the time of submission of

its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

3.4.3. The Proposer must clearly designate the part of the proposal that contains a trade secret and/or privileged or confidential proprietary information as "confidential" in order to claim protection, if any, from disclosure. The Proposer shall mark the cover sheet of the proposal with the following legend, specifying the specific section(s) of the proposal sought to be restricted in accordance with the conditions of the legend:

"The data contained in pages _____ of the proposal have been submitted in confidence and contain trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions."

3.4.4. Further, to protect such data, each page containing such data shall be specifically identified and marked "CONFIDENTIAL".

3.4.5. Proposers must be prepared to defend the reasons why the material should be held confidential. If a competing proposer or other person seeks review or copies of another proposer's confidential data, DHH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain DHH from releasing information DHH believes to be public record.

3.4.6. If the proposal contains confidential information, a redacted copy of the proposal must be submitted. If a redacted copy is not submitted, DHH may consider the entire proposal to be public record. When submitting the redacted copy, it should be clearly marked on the cover as - "REDACTED COPY". The redacted copy should also state which sections or information has been removed."

3.4.7. Any proposal marked as confidential or proprietary in its entirety may be rejected without further consideration or recourse.

3.5. PROPOSAL COST

3.5.1. The Proposer assumes sole responsibility for any and all costs associated with the preparation and reproduction of any proposal submitted in response to this RFP, and shall not include this cost or any portion thereof in the proposed contract price.

3.6. OWNERSHIP OF PROPOSAL

3.6.1. All proposals become the property of DHH and will not be returned to the Proposer. DHH retains the right to use any and all ideas or adaptations of ideas contained in any proposal received in response to this solicitation. Selection or rejection of the offer will not affect this right. Once a contract is awarded, all proposals will become subject to the Louisiana Public Records Act.

3.7. CERTIFICATION STATEMENT

3.7.1. The Proposer must sign and submit the attached Certification Statement (see Attachment I).

3.8. PROPOSAL SUBMISSION

3.8.1. This section outlines proposal provisions that determine compliance of each Proposer's response to the RFP. Failure to comply with any mandatory requirement shall result in the rejection of the proposal. The agency shall determine, at its sole discretion, whether or not the RFP provisions have been reasonably met. The proposal should describe the background and capabilities of the Proposer, give details on how the services will be provided, and must include a breakdown of proposed costs. It should also include information that will assist DHH in determining the level of quality and timeliness that may be expected. Work samples may be included as part of the proposal.

3.8.2. An Item-by-item response to the Request for Proposal is requested.

3.8.3. There is no intent to limit the content of the proposals, and Proposers may include any additional information deemed pertinent. Emphasis should be on simple straightforward and concise statements of the Proposer’s ability

to satisfy the requirements of the RFP. Innovative approaches are encouraged.

3.8.4. Requested Proposal Outline

3.8.4.1. Introduction
3.8.4.2. Understanding of Project Scope
3.8.4.3. Data Management
3.8.4.4. Work Plan/Project Implementation
3.8.4.5. Relevant Corporate Experience
3.8.4.6. Corporate Financial Condition
3.8.4.7. Personnel Qualifications
3.8.4.8. Cost and Pricing Analysis
3.8.4.9. Administrative Data
3.8.4.10. Assignments
3.8.4.11. Additional Information
3.8.4.12. Warranty Against Cost Disclosure and Broker Fees
3.8.4.13. Location of Office with Full Time Personnel

3.9. CONTENT OF PROPOSAL OUTLINE

3.9.1. Introduction

3.9.1.1. The introductory section should contain summary information about the Proposer's organization and its ability to satisfy provisions of the Request for Proposal. This section should also include an organizational chart displaying the Proposer's overall structure.

3.9.2. Understanding of Project Scope, Needs, and Objectives

3.9.2.1. This section should demonstrate the Proposer's knowledge and understanding of the needs and objectives of DHH. The Proposer should use their knowledge and expertise to demonstrate their understanding of the overall Scope of Work, including DHH, and Medicaid. This section should contain work statements reflecting the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems.

3.9.2.2. The practicality of the execution of each stage of the project will be examined. The Proposer should provide a detailed breakdown of

how the requested services will be provided. The rationale and methodology for achieving objectives will be considered as well as the Proposer's organizational approach to the project. Proposals should define Proposer's functional approach in providing services and identify the tasks necessary to meet the RFP requirements.

3.9.2.3. The proposed plan must provide a benefit package based on the FEHBP Standard Option benchmark plan administered by Metropolitan Life Insurance Company, which includes cost sharing requirements, items and services, and limitations including aggregate dollar limits. The proposer should describe the proposed benefit plan in detail that meets or exceeds the following minimum requirements listed:

3.9.2.3.1. Dental benefit coverage for children that includes preventative visit(s), exams, x-rays, cleaning, basic restorative, and treatment services based on cost effective, evidence-based standards of practice within the dental community;

3.9.2.3.2. Include identification of any caps and/or limitations to the benefit package;

3.9.2.3.3. A list of services that require pre-certification; and

3.9.2.3.4. List the Current Dental Terminology Codes (CDT) that will be included in your proposed insurance coverage.

3.9.2.3.5. Describe the service delivery system to include at a minimum:

3.9.2.3.5.1. How identification cards are obtained;

3.9.2.3.5.2. How information regarding network of providers be disseminated to members; and

3.9.2.3.5.3. Pre-certification procedures.

3.9.2.3.6. Describe strategies to ensure comprehensive dental care is available and individuals most in need are identified and receive priority for care and treatment;

3.9.2.3.7. Describe how the system will use evidence-based best practices for treatment and patient care;

3.9.2.3.8. Identify partnerships that might be formed, for example, with school based health centers, Federally Qualified Health

Centers (FQHC) and existing dental practices;

3.9.2.3.9. Describe ability to maintain a call center for member and provider inquiries;

3.9.2.3.10. Provide electronic copies of all training materials and a description of methods used for training staff

3.9.2.3.11. Describe how quality improvement and HEDIS measures will be meet and collected;

3.9.2.3.12. Describe a timeline necessary for implementation;

3.9.2.3.13. Identify the state and effective date of Certificate of Authority to transact the business of dental services;

3.9.2.3.14. Describe methods used to enroll, train and support a network of qualified dental providers adequate to provide access to dental care for all members; and

3.9.2.3.15. Describe dental education and member outreach strategies.

3.9.2.4. Attachment V provides details from the FEHBP Standard Option plan administered by Metropolitan Life Insurance Company. This plan is a benchmark for which the proposer's plan must meet or exceed. The proposer must submit information on Attachment V that addresses whether or not the dental service or supply is provided under the proposed plan, any limitations associated with the described service, any co-insurance required, and any co-pay required.

3.9.3. Disaster Recovery

3.9.3.1. The Proposer's Disaster Recovery and Business Continuity Plan (DR/BCP) and procedures should be submitted with the proposal.. The plans should include: Risk Management, Business Impact Analysis, Alignment to Business Strategy, Alignment to Business Continuity Strategy, and Testing and Updating Plans.

3.9.4. Transition/Takeover Plan

3.9.4.1. The Proposer should submit, with its response to this RFP, a transition/takeover plan which outlines the procedures and timelines to ensure continuity of services in the event of contract

termination or award of contract to another contractor. The transition/takeover plan should include procedures that should, at a minimum, comply with the following stipulations:

3.9.4.2. Upon completion of this contract or if terminated earlier, all records, reports, work sheets or any other materials related to the execution of this contract shall become the property of DHH;

3.9.4.3. In the event of contract termination, or as requested, the proposed plan should indicate the process whereby all data and non-proprietary systems are transferred to DHH or a new contractor within the agreed upon time frame.

3.9.4.4. Upon termination of contracted services, all equipment purchased under this agreement shall revert to DHH. The proposed plan should include provisions for the delivery of any such equipment to DHH within the pre-determined time frame.

3.9.4.5. The transition/takeover plans must be adhered to within thirty (30) calendar days of written notification of contract termination, unless other appropriate time frames have been mutually agreed upon by both the Dental Plan and DHH.

3.9.5. Project Work Plan

3.9.5.1. The Proposal should state the approach to be used to achieve each objective of the project including major activities and methodologies utilized for each work statement, as well as Department involvement. The Proposal should state how each objective of the project will be accomplished.

3.9.5.2. This section should address the project work plan and provide a work schedule for each phase of the project. The work plan should be presented as follows:

3.9.5.2.1. Provide a written discussion of the work plan addressing process flow, time frames for each component;

3.9.5.2.2. Explain how findings will be addressed in the process; and the ability to maintain the work plan schedule (i.e. drawing on firm resources, training, etc.);

3.9.5.2.3. Provide a strategic overview including all elements to be provided;

3.9.5.2.4. Breakdown into logical tasks and time frames all work to be performed, accompanied by an assessment of relative difficulty for each task;

3.9.5.2.5. Identify critical tasks;

3.9.5.2.6. Estimate time involved in completion of tasks;

3.9.5.2.7. Identify all assumptions or constraints on tasks;

3.9.5.2.8. Refer to specific documents and reports that are to be produced as a result of completing tasks. Contain a summary, at the activity level, to show completion schedules relative to deliverables;

3.9.5.2.9. Include charts and graphs which reflect the work plan in detail;

3.9.5.2.10. Describe the approach to Project Management and Quality Assurance;

3.9.5.2.11. Discuss what flexibility exists within the work plan to address unanticipated problems which might develop during the contract period;

3.9.5.2.12. If the Proposer intends to subcontract for portions of the work, the Proposer must include specific designations of the tasks to be performed by the subcontractor; and

3.9.5.2.13. Document procedures to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

3.9.6. Relevant Corporate Experience

3.9.6.1. The proposal should indicate the firm has a record of prior successful experience in the design and implementation of the services sought through this RFP. Proposers should include statements specifying the extent of responsibility on prior projects and a description of such projects scope and similarity to the projects outlined in this RFP. All experience under this section should be in sufficient detail to allow an adequate evaluation by

DHH. In particular, the Proposer should demonstrate prior experience with the development, implementation, and maintenance of a Dental Plan. The Proposer should have, within the last twenty-four (24) months, completed a similar type project. Proposers should give at least two (2) customer references for projects completed in at least the last twenty-four (24) months. References should include the name and telephone number of each contact person.

3.9.6.2. Proposers should include any pertinent accreditations, certifications, or licensing obtained by the corporate entity that would enhance the integrity of the proposer's work on this project.

3.9.6.3. In this section, a statement of the Proposer's involvement in litigation that could affect this work should be included. If no such litigation exists, Proposer should so state.

3.9.7. Corporate Financial Condition

3.9.7.1. The organization's financial solvency will be evaluated. The Proposer's ability to demonstrate adequate financial resources for performance of the contract or the ability to obtain such resources as required during performance under this contract will be given special emphasis.

3.9.7.2. The proposal should include for each of the last three (3) years, copies of financial statements, preferably audited, including at least a balance sheet and profit and loss statement, or other appropriate documentation which would demonstrate to DHH the Proposer's financial resources sufficient to conduct the project.

3.9.8. Personnel Qualifications

3.9.8.1. This section should include the key factors which the Proposer understands will be considered in the staffing and management of the project.

3.9.8.2. The purpose of this section is to evaluate the relevant experience, resources, and qualifications of the proposed staff to be assigned to this project. The experience of Proposer's personnel in

implementing similar services to those to be provided under this RFP will also be evaluated. The Proposer should also include a statement of its ability to commit key personnel for the full-term of the contract, three(3) years, and its plan for doing so. The adequacy of personnel for the proposed project team will be evaluated on the basis of project tasks, allocation of staff, professional skill mix, and level of involvement of personnel. Personnel should be identified, and should be the individuals who will work directly on the project. Percentage of time, work-hours committed or other identification of the proposed level of effort should be submitted.

3.9.8.3. Job descriptions for all staff should be included and should indicate minimum education, training, experience, special skills and other qualifications for each staff position as well as specific job duties identified in the proposal. Proposers should also state job responsibilities, workload and lines of supervision. An organizational chart identifying individuals and their job titles and major job duties as well as indication of full- or part-time participation should be included. The organizational chart should show lines of responsibility and authority. The Proposer should clearly show how the organizational structure is designed to carry out the responsibilities within each of the major components.

3.9.8.4. Key personnel should be designated as such in the proposal, and résumés of all known personnel must be included. Resumes of key personnel proposed should include, but not be limited to:

3.9.8.4.1. Experience with Proposer.

3.9.8.4.2. Previous experience in projects of similar scope and size.

3.9.8.4.3. Where personnel have previously worked as a team on similar projects, résumé data should include responsibility and position within the team.

3.9.8.4.4. Educational background, certifications, licenses, special skills, etc.

3.9.8.5. If subcontractor personnel will be used, the Proposer should clearly identify these persons and provide the same information requested for the Proposer's personnel.

3.9.9. Cost and Pricing Analysis

3.9.9.1. Proposers must provide cost for the FEHBP Standard Option, utilizing Table1 (Attachment IV), based on a prepaid, Per Member Per Month (PMPM) payment arrangement. Cost shall be provided for all Regions (1-9) and for every Age Group specified on Table 1. Failure to provide a PMPM cost for every region and every age group shall be cause for DHH to reject the proposal. PMPM cost shall include:

3.9.9.1.1. Dental items and services to specific age and gender groups and administrative costs including, but not limited to, call center, provider recruitment and contracting, claims payment, member outreach, and reporting requirements.

3.9.9.1.2. In the development of the costs, proposers shall adhere to the following regulations related to imposition of cost sharing charges and exclusions:

3.9.9.1.2.1. Cost sharing shall not be charged for well-child and well-baby visits. This includes routine preventive and diagnostic dental services described in the most recent guidelines issued by the American Academy of Pediatric Dentistry in accordance with 42 CFR 457.520;

3.9.9.1.2.2. Cost sharing charges shall not be imposed for American Indian or Alaskan natives in accordance with 42 CFR 457.535

3.9.9.1.2.3. Cost sharing for healthcare and dental shall not exceed 5% of family income for the length of the child's eligibility period in accordance with 42 CFR 457.560; and

3.9.9.1.2.4. Proposers must comply with the pre-existing condition exclusion in accordance with 42 CFR 457.480.

3.9.9.2. Proposers are advised that they will be required to interface with the LaCHIP Affordable Plan Contractor by providing specified dental cost sharing data electronically, as defined by the LaCHIP Affordable Plan Contractor, to ensure that total cost sharing liability does not exceed the cumulative cost sharing maximum.

3.9.10. Administrative Data

3.9.10.1. The proposal should include the following administrative data:

3.9.10.1.1. Name and address of principal officer;

3.9.10.1.2. Name and address for purpose of issuing checks and/or drafts;

3.9.10.1.3. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation;

3.9.10.1.4. If out-of-state Proposer, give name and address of local representative; if none, so state;

3.9.10.1.5. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;

3.9.10.1.6. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state; and

3.9.10.1.7. Proposer's state and federal tax identification numbers.

3.9.10.2. The following mandatory administrative data should also be included in this section:

3.9.10.2.1. Proposer shall guarantee that there will be no conflict or violation of the Ethics Code if it is awarded the contract. Ethics issues are interpreted by the Louisiana Board of Ethics.

3.9.10.2.2. Proposer shall guarantee that the entire proposal will be valid for a period of one hundred and twenty (120) days after the submission date.

3.9.10.2.3. Proposer shall guarantee that the proposal submitted shall become a contractual obligation and valid if a contract is awarded.

3.9.11. Assignments

3.9.11.1. Any assignment, pledge, joint venture, hypothecation of right or responsibility to any person, firm or corporation should be fully explained and detailed in the proposal. Information as to the experience and qualifications of proposed subcontractors or joint ventures should be included in the proposal. In addition, written commitments from any subcontractors or joint ventures should be included as part of the proposal.

3.9.12. Additional Information

3.9.12.1. Proposers may be required by DHH to provide additional information or clarification concerning proposals.

3.9.13. Warranties

3.9.13.1. The following two (2) items should be included in the proposal:

3.9.13.1.1. Warranty Against Cost Disclosure: The Proposer should warrant that it has not discussed or disclosed price or cost data with DHH prior to the opening of the proposal and that all price and/or cost data have been arrived at independently without consultation, communication or agreement with any competitor.

3.9.13.1.2. Warranty Against Broker's Fees: The Proposer should warrant that it has not employed any company or person other than a bona fide employee working solely for the Proposer or a company regularly employed as its marketing agent to solicit or secure the contract and should also warrant that it has not paid or agreed to pay any company or person other than the bona fide employee working solely for the Proposer as its marketing agent any fee, commission, percentage, brokerage fee, gifts, or any other consideration contingent upon or

resulting from the award of the contract.

3.10.CRITERIA FOR EVALUATION

3.10.1. Evaluations will be conducted by a Proposal Review Committee.

3.10.2. Evaluations of the financial statements will be conducted by a member of the DHH Fiscal Division.

3.10.3. Scoring will be based on a possible total of 100 points. Each evaluator will score each proposal and the proposal with the highest combined total score will be recommended for award.

3.10.4. **Cost Evaluation:**

3.10.4.1. A maximum of 30 points will be assigned to Cost. The Proposer with the lowest total cost shall receive 25 points. Total cost shall be determined by adding PMPM costs for every age group in every region defined on Attachment IV. Other Proposers shall receive points for cost based upon the following formula:

CPS = (LPC/PC)* 25

CPS = Cost Proposal Score
LPC = Lowest Proposal Cost of all Proposers
PC = Individual Proposal Cost

3.10.4.2. The assignment of the 25 points based on the above formula will be calculated by a member of the DHH Contracts Office staff.

3.10.4.3. Additionally, a maximum of 5 points may be awarded for the cost criteria based on evaluation of reasonableness of the PMPM based on economies of scale and justification that all cost is consistent with the purpose, objectives, and deliverables of the RFP.

3.10.4.4. The DHH Deputy Undersecretary may provide assistance with the evaluation of the additional 5 points.

3.11. EVALUATION CRITERIA AND ASSIGNED WEIGHTS

3.11.1. The following criteria will be used to evaluate proposals. The criteria and assigned weights are:

Evaluation Criteria	
Introduction/Understanding of Scope of Work	5
Work Plan/Project Execution	30
Corporate Experience	10
Qualifications of Personnel	20
Financial Condition	5
Cost	30
Point Total	100
On-site Demonstrations (optional at the discretion of DHH to select those proposers considered susceptible to award for on-site demonstrations)	5
Total Possible Points	105

3.12. ANNOUNCEMENT OF AWARD

3.12.1. DHH will award the contract to the Proposer with the highest graded proposal and deemed to be in the best interest of DHH. All Proposers will be notified of the contract award. DHH will notify the successful Proposer and proceed to negotiate contract terms.

4. OTHER LOGISTICS

4.1. CONTACT AFTER SOLICITATION DEADLINE

4.1.1. After the date for receipt of proposals, no Proposer-initiated contact relative to the solicitation will be allowed between the Proposers and DHH until the award is made.

4.2. REJECTION AND CANCELLATION

4.2.1. Issuance of this solicitation does not constitute a commitment by DHH to award a contract or contracts. DHH reserves the right to reject any or all proposals received in response to this solicitation.

4.3. COMPLETENESS OF INFORMATION

4.3.1. Failure to furnish mandatory information specifically required in this solicitation shall disqualify a proposal.

4.4. AWARD WITHOUT DISCUSSION

4.4.1. The Secretary of DHH reserves the right to make an award without on-site demonstrations by Proposers or further discussion of proposals received.

5. CONTRACTUAL TERMS

5.1. The contract between DHH and the Dental Plan shall include the standard DHH contract form (CF-1) including a negotiated Scope of Work, the RFP and its amendments and addenda, and the Dental Plan's proposal. The attached CF-1 contains basic information and general terms and conditions of the contract to be awarded.

5.2. Mutual Obligations and Responsibilities: The State requires that the mutual obligations and responsibilities of DHH and the successful Proposer be recorded in a written contract. While final wording will be resolved at contract time, the intent of the provisions will not be altered and will include all provisions as specified in the attached CF-1.

5.3. In addition, to terms of the CF-1 and supplements, the following will be incorporated into the contract awarded through this RFP:

5.3.1. Personnel Assignments: The Dental Plan's key personnel assigned to this contract may not be replaced without the written consent of DHH. Such consent shall not be unreasonably withheld or delayed provided an equally qualified replacement is offered. Key personnel for these purposes will be determined during contract negotiation.

5.3.2. Force Majeure: The Dental Plan and DHH are excused from performance under contract for any period they may be prevented from performance by an Act of God, strike, war, civil disturbance, epidemic or court order.

5.3.3. Order of Precedence: The contract shall, to the extent possible, be construed to give effect to all provisions contained therein; however, where provisions conflict, the intent of the parties shall be determined by giving a first priority to provisions of the contract excluding the RFP and

the proposal; second priority to the provisions of the RFP; and third priority to the provisions of the proposal.

5.3.4. Entire Agreement: This contract, together with the RFP and addenda issued thereto by DHH, the proposal submitted by the Dental Plan in response to DHH's RFP, and any exhibits specifically incorporated herein by reference constitute the entire agreement between the parties with respect o the subject matter.

5.3.5. Board Resolution/Signature Authority: The Dental Plan, if a corporation, shall secure and attach to the contract a formal Board Resolution indicating the signatory to the contract is a corporate representative and authorized to sign said contract.

5.3.6. Warranty to Comply with State and Federal Regulations: The Dental Plan shall warrant that it shall comply with all State and Federal regulations as they exist at the time of the contract or as subsequently amended.

5.3.7. Warranty of Removal of Conflict of Interest: The Dental Plan shall warrant that it, its officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. The Dental Plan shall periodically inquire of its officers and employees concerning such conflicts, and shall inform DHH promptly of any potential conflict. The Dental Plan shall warrant that it shall remove any conflict of interest prior to signing the contract.

5.3.8. If the Dental Plan is a corporation, the following requirement must be met prior to execution of the contract:

5.3.8.1. If a for-profit corporation whose stock is not publicly traded-the Dental Plan must file a Disclosure of Ownership form with the Louisiana Secretary of State.

5.3.8.2. If the Dental Plan is a corporation not incorporated under the laws of the State of Louisiana-the Dental Plan must obtain a Certificate of Authority pursuant to R.S. 12:301-302 from the Louisiana Secretary of State.

5.3.8.3. The Dental Plan must provide written assurance to the agency from Dental Plan's legal counsel that the Dental Plan is not prohibited by its articles of incorporation, bylaws or the laws under which it is incorporated from performing the services required under the contract.

Attachments:

I: Certification Statement
II: DHH Standard Contract Form (CF-1)
III: HIPAA
IV: Prepaid PMPM Cost
V: Proposed Dental Benefit Plan

CERTIFICATION STATEMENT ATTACHMENT I

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The Department requests that the proposer designate one person to receive all documents. Identify the Contact name and fill in the information below:

Date	
Official Contact Name	
Email Address	
Fax Number with Area Code	
Telephone Number	
Street Address	
City, State, and Zip	

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;

2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.

Authorized Signature: _____

Typed or Printed Name: _____

Title: _____

Company Name: _____

Attachment II **DHH - CF - 1**

AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

AND

FOR

☐ Personal Services ☐ Professional Services ☐ Consulting Services ☐ Social Services

1) Contractor (Legal Name if Corporation)	**5) Federal Employer Tax ID# or Social Security # (11 digits)**
2) Street Address	**6) Parish(es) Served**
City and State **Zip Code**	**7) License or Certification #**
3) Telephone Number	**8) Contractor Status**
4) Mailing Address (if different)	Subrecipient: ☐ Yes ☐ No Corporation: ☐ Yes ☐ No For Profit: ☐ Yes ☐ No Publicly Traded: ☐ Yes ☐ No
City and State **Zip Code**	**8a) CFDA#(Federal Grant #)**

9) Brief Description Of Services To Be Provided:
Include description of work to be performed and objectives to be met; description of reports or other deliverables and dates to be received (when applicable). In a consulting service, a resume of key contract personnel performing duties under the terms of the contract and amount of effort each will provide under terms of contract should be attached**.**

10) Effective Date	**11) Termination Date**

12) This contract may be terminated by either party upon giving thirty (30) days advance written notice to the other party with or without cause but in no case shall continue beyond the specified termination date.

13) Maximum Contract Amount

14) Terms of Payment
If progress and/or completion of services are provided to the satisfaction of the initiating Office/Facility, payments are to be made as follows: (stipulate rate or standard of payment, billing intervals, invoicing provisions, etc.). Contractor obligated to submit final invoices to Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**Name**	
	Title	**Phone Number**

15) Special or Additional Provisions which are incorporated herein, if any (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):

During the performance of this agreement, the Contractor hereby agrees to the following terms and conditions:

1. Contractor hereby agrees to adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, sexual orientation, or any other non-merit factor.

2. Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)

3. The State Legislative Auditor, Office of the Governor, Division of Administration Auditors and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.

   Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. All audit fees and other costs associated with the audit shall be paid entirely by the Contractor. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (**4) copies** of the audit report shall be sent to the Department of Health and Hospitals, **Attention: Division of Fiscal Management, P.O. Box 91117, Baton Rouge, LA 70821-3797** and **one (1) copy** of the audit shall be sent to the **originating DHH Office**.

4. Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department. If Medicare reimbursable, these shall be made available to the Secretary, U.S. DHHS and the U.S. Comptroller General, and their representatives to certify the nature and extent of costs of services, as provided at Section 2440.4 of the Provider Reimbursement Manual (HIM 15-1).

5. Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the State.

6. Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this agreement shall be Contractor's. The contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for social security and withholding taxes, contributions for unemployment compensation funds, and shall maintain, at Contractor's expense, all

necessary insurance for its employees, including but not limited to workers compensation and liability insurance.

7. In consideration for goods delivered or services performed, the Department shall make all checks payable to the contractor in the amounts and intervals as expressed or specified in the agreement. In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations and are specified under "Special Provisions." The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses. When applicable, the amounts may be stated by category and then as a comprehensive total.

8. No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition of matter having the effect of law being considered by the legislature or any local governing authority. Contracts with individuals shall be exempt from this provision.

9. Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.

10. Upon completion of this contract or if terminated earlier, all records, reports, work sheets or any other materials related to this contract shall become the property of the Department.

11. Contractor shall not enter into any subcontract for work or services contemplated under this agreement without obtaining prior written approval of the Department (which approval shall be attached to the original agreement). Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this agreement, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this agreement; and provided, further, however that no provisions of this clause and no such approval by the Department or any subcontract shall be deemed in any event or manner to provide for the incidence of any obligation of the Department beyond those specifically set forth herein. Further provided that no subcontract shall relieve the Contractor of the responsibility for the performance of any subcontractor.

12. Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, duly signed, and attached to the original of this agreement. No claim for services furnished or requested for reimbursement by Contractor, not provided for in this agreement, shall be allowed by the Department. This contract is not effective until approved by the required authorities of the Department and if contract exceeds $20,000, the Director of the Office of Contractual Review in accordance with La. R.S. 39:1502. It is the responsibility of Contractor to advise the agency in advance if contract funds or contract terms may be insufficient to complete contract objectives.

13. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous agreements are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this agreement for costs that are allowable.

14. This agreement is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until agreement has been approved by required authorities of the Department; and, if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration.

The continuation of this contract is contingent upon the appropriation of funds to fulfill the requirements of the contract by the Legislature. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated.

15. Any amendment to this agreement shall not be valid until it has been executed by the Undersecretary or Assistant Secretary or other designated authority of the Office which is a party to the contract, and the Contractor and approved by required authority of the Department; and; if contract exceeds $20,000, the Director of the Office of Contractual Review, Division of Administration. Budget revisions in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.

16. Any contract disputes will be interpreted under applicable Louisiana laws in Louisiana administrative tribunals or district courts as appropriate.

17. Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful**. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.**

18. Contractor agrees that purchase of equipment under the terms of this agreement shall require prior approval of the Department and shall conform to bid and inventory requirements as set forth in the Property Control Manual for Contracting Agencies and which comply with the Louisiana Procurement Code and property control regulations.

Any equipment purchased under this agreement remains the property of the Contractor for the period of this agreement and future continuing agreements for the provision of the same services. For the purpose of this agreement, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $250.00 or more. The contractor has the responsibility to submit to the Program Office Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor agrees that upon termination of contracted services, the equipment purchased under this agreement reverts to the State. Contractor agrees to deliver any such equipment to the State.

19. Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. **This provision does not apply to actions or omissions for which LA R.S. 40:1299.39 provides malpractice coverage to the contractor, nor**

claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further it does not apply to premise liability when the services are being performed on premises owned and operated by DHH.

20. Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.

21. Contractor agrees that the current contract supersedes all previous contracts, agreements, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.

THIS AGREEMENT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS AGREEMENT IS SIGNED AND ENTERED INTO ON THE DATE INDICATED BELOW.

CONTRACTOR	**STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS**
CONTRACTOR	
SIGNATURE **DATE**	Alan Levine **DATE**
NAME	
TITLE	

(Name of Regional Office, Facility)	**(OFFICE NAME)**
SIGNATURE **DATE**	**SIGNATURE** **DATE**
NAME	**NAME**
TITLE	**TITLE** Assistant Secretary

Attachment III

(Rev. 1/04)

HIPAA Business Associate Addendum:

This Business Associate Addendum is hereby made a part of this contract in its entirety as Attachment __ to the contract.

1. The U. S. Department of Health and Human Services has issued final regulations, pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), governing the privacy of individually identifiable health information. See 45 CFR Parts 160 and 164 (the "HIPAA Privacy Rule"). The Department of Health and Hospitals, ("DHH"), as a "Covered Entity" as defined by HIPAA, is a provider of health care, a health plan, or otherwise has possession, custody or control of health care information or records.
2. "*Protected health information*" ("PHI") means individually identifiable health information including all information, data, documentation and records, including but not limited to demographic, medical and financial information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual or payment for health care provided to an individual; and that identifies the individual or which DHH believes could be used to identify the individual.

   "*Electronic protected health information*" means PHI that is transmitted by electronic media or maintained in electronic media.

   "*Security incident*" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
3. Contractor is considered a Business Associate of DHH, as contractor either: (A) performs certain functions on behalf of or for DHH involving the use or disclosure of protected individually identifiable health information by DHH to contractor, or the creation or receipt of PHI by contractor on behalf of DHH; or (B) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, financial or social services for DHH involving the disclosure of PHI.
4. Contractor agrees that all PHI obtained as a result of this contractual agreement shall be kept confidential by contractor, its agents, employees, successors and assigns as required by HIPAA law and regulations and by this contract and addendum.
5. Contractor agrees to use or disclose PHI solely (A) for meeting its obligations under this contract, or (B) as required by law, rule or regulation or as otherwise permitted under this contract or the HIPAA Privacy Rule.
6. Contractor agrees that at termination of the contract, or upon request of DHH, whichever occurs first, contractor will return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor will extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.
7. Contractor will ensure that its agents, employees, subcontractors or others to whom it provides PHI received by or created by contractor on behalf of DHH agree to the same restrictions and conditions that apply to contractor with respect to such information. Contractor also agrees to take all reasonable steps to ensure that its employees', agents' or subcontractors' actions or omissions do not cause contractor to breach the terms of this Addendum. Contractor will use all appropriate safeguards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this contract and Addendum.
8. Contractor shall, within 3 days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and Addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1.
9. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR 164.528 for at least six (6) years after the date of

the last such disclosure.

10. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR 164.524.
11. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR 164.526.
12. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Privacy Rule.
13. Compliance with Security Regulations:
    In addition to the other provisions of this Addendum, if Contractor creates, receives, maintains, or transmits electronic PHI on DHH's behalf, Contractor shall, no later than April 20, 2005:
    (A) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH;
    (B) Ensure that any agent, including a subcontractor, to whom it provides such information agrees to implement reasonable and appropriate safeguards to protect it; and
    (C) Report to DHH any security incident of which it becomes aware.
14. Contractor agrees to indemnify and hold DHH harmless from and against all liability and costs, including attorneys' fees, created by a breach of this Addendum by contractor, its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any material term of this Addendum.

Table 1: Prepaid PMPM Costs

	Ages 0-5, M & F	Ages 6-11, M & F	Ages 11-19, M & F
Region 1			
Region 2			
Region 3			
Region 4			
Region 5			
Region 6			
Region 7			
Region 8			
Region 9			
SUBTOTALS (Regions 1-9)			

TOTAL **$_____**
(Subtotals for 3 age groups)

Attachment V: Proposed Dental Benefit

Name of Company:	
Benefit Plan:	
Enrollment:	

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D0120	PERIODIC ORAL EXAMINATION	Yes	1 every 6 months	0%				
D0140	LIMIT ORAL EVAL PROBLEM FOCUSED	Yes	1 every 6 months	0%				
D0150	COMPREHENSIVE ORAL EVALUATION	Yes	1 every 6 months	0%				
D0160	DETAILED AND EXTENSIVE ORAL EVALUATION PROBLEM FOCUSED	Yes		65%				
D0180	COMPREHENSIVE PERIODONTAL EVALUATION	Yes	1 every 6 months	0%				
D0210	INTRAORAL COMPLETE FILM SERIES	Yes	1 every 60 months	0%				
D0220	PERIAPICAL X RAY; FIRST FILM	Yes		0%				
D0230	PERIAPICAL X RAY; EACH ADDITIONAL FILM	Yes		0%				
D0240	OCCLUSAL X RAY	Yes		0%				
D0270	BITEWING, SINGLE FIRST FILM	Yes	1 set every 6 months	0%				
D0272	BITEWINGS TWO FILMS	Yes	1 set every 6 months	0%				
D0274	BITEWINGS FOUR FILMS	Yes	1 set every 6 months	0%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D0277	VERTICAL BITEWINGS 7 TO 8 FILMS	Yes	1 set every 6 months	0%				
D0330	PANORAMIC FILM	Yes	1 film every 60 months	0%				
D0473	ACCESSION OF TISSUE, GROSS & MICRO EXAM. PREP & TRANS RPT	Not Covered						
D0474	ACCESSION OF TISSUE, GROSS & MICRO EXAM. ASSESS PRESENCE OF DISEASE	Not Covered						
D1110	PREVENTIVE PROPHYLAXIS (ADULT)	Yes	1 every 6 months	0%				
D1120	PREVENTIVE PROPHYLAXIS (CHILD)	Yes	1 every 6 months	0%				
D1203	TOPICAL FLUORIDE W/O PROPHY CHILD	Yes	2 every 12 months	0%				
D1204	TOPICAL FLUORIDE W/O PROPHY ADULT	Yes	2 every 12 months	0%				
D1206	TOPICAL FLOURIDE VARNISH	Yes	2 in 12 months	0%				
D1351	DENTAL SEALANT PER TOOTH	Yes	Less than age 18 – 1 per tooth every 36 months	0%				
D1510	SPACE MAINTAINER – FIXED UNILATERAL	Yes	Limited to Children under age 19	0%				
D1515	SPACE MAINTAINER – FIXED BILATERAL	Yes	Children under age 19	0%				
D1520	SPACE MAINTAINER – REMOVABLE UNILATERAL	Yes	Children under age 19	0%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D1525	SPACE MAINTAINER – REMOVABLE BILATERAL	Yes	Children under age 19	0%				
D1550	RE-CEMENTATION OF SPACE MAINTAINER	Yes	Children under age 19	0%				
D2140	AMALGAM ONE SURFACE, PRIMARY OR PERMANENT	Yes		45%				
D2150	AMALGAM TWO SURFACES, PRIMARY OR PERMANENT	Yes		45%				
D2160	AMALGAM THREE SURFACES, PRIMARY OR PERMANENT	Yes		45%				
D2161	AMALGAM FOUR SURFACES, PRIMARY OR PERMANENT	Yes		45%				
D2330	RESIN-BASED COMPOSITE ONE SURFACE ANTERIOR	Yes		45%				
D2331	RESIN-BASED COMPOSITE TWO SURFACES ANTERIOR	Yes		45%				
D2332	RESIN-BASED COMPOSITE THREE SURFACES ANTERIOR	Yes		45%				
D2335	RESIN-BASED COMPOSITE FOUR OR MORE SURFACES ANTERIOR	Yes		45%				
D2390	RESIN-BASED COMPOSITE CROWN ANTERIOR	Not Covered						
D2510	INLAY-METALLIC-ONE SURFACE	Yes	Alternate benefit will be provided	65%				
D2520	INLAY-METALLIC-TWO SURFACES	Yes	Alternate benefit will be provided	65%				
D2530	INLAY-METALLIC-THREE OR MORE SURFACES	Yes	Alternate benefit will be	65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
			provided					
D2542	ONLAY-METALLIC-TWO SURFACES	Yes	1 per tooth every 60 months	65%				
D2543	ONLAY-METALLIC-THREE SURFACES	Yes	1 per tooth every 60 months	65%				
D2544	ONLAY-METALLIC-FOUR OR MORE SURFACES	Yes	1 per tooth every 60 months	65%				
D2740	CROWN-PORCELAIN/CERAMIC SUBSTRATE	Yes	1 per tooth every 60 months	65%				
D2750	CROWN-PORCELAIN FUSED TO HIGH NOBLE METAL	Yes	1 per tooth every 60 months	65%				
D2751	CROWN-PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Yes	1 per tooth every 60 months	65%				
D2752	CROWN-PORCELAIN FUSED TO NOBLE METAL	Yes	1 per tooth every 60 months	65%				
D2780	CROWN-3/4 CAST HIGH NOBLE METAL	Yes	1 per tooth every 60 months	65%				
D2781	CROWN-3/4 CAST PREDOMINANTLY BASE METAL	Yes	1 per tooth every 60 months	65%				
D2783	CROWN-3/4 PORCELAIN/CERAMIC	Yes	1 per tooth every 60 months	65%				
D2790	CROWN FULL CAST HIGH NOBLE METAL	Yes	1 per tooth every 60 months	65%				
D2791	CROWN-FULL CAST PREDOMINANTLY BASE	Yes	1 per tooth every 60	65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	METAL		months					
D2792	CROWN-FULL CAST NOBLE METAL	Yes	1 per tooth every 60 months	65%				
D2794	CROWN-TITANIUM	Yes	1 per tooth every 60 months	65%				
D2910	RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORIATION	Yes		45%				
D2920	RECEMENT CROWN	Yes		45%				
D2930	PREFAB STAINLESS STEEL CROWN – PRIMARY TOOTH	Yes	1 per tooth in 60 months	45%				
D2931	PREFAB STAINLESS STEEL CROWN – PERMANENT TOOTH	Yes	1 per tooth in 60 months	45%				
D2950	CORE BUILDUP INCLUDING ANY PINS	Yes	1 per tooth every 60 months	65%				
D2951	PIN RETENTION PER TOOTH IN ADDITION TO RESTORATION	Yes		45%				
D2954	PREFABRICATED POST AND CORE, IN ADDITION TO CROWN	Yes	1 per tooth every 60 months	65%				
D2980	CROWN REPAIR, BY REPORT	Yes		65%				
D3220	THERAPEUTIC PULPOTOMY EXCLUDING FINAL RESTORATION	Yes	If root canal is within 45 days – not covered	45%				
D3222	PARTIAL PULPOTOMY FOR APEXOGENESIS	Yes	If root canal is within 45 days – not	45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
			covered					
D3230	PULPAL THERAPY ANTERIOR PRIMARY TOOTH	Yes	Limited to primary incisor teeth for up to age 6 and for primary molars and cuspids up to age 11 and limited to once per tooth per lifetime	45%				
D3240	PULPAL THERAPY POSTERIOR PRIMARY TOOTH	Yes	If root canal is within 45 days – not covered	45%				
D3310	ENDODONTIC THERAPY ANTERIOR EXCLUDES FINAL RESTORATION	Yes		65%				
D3320	ENDODONTIC THERAPY BICUSPID EXCLUDES FINAL RESTORATION	Yes		65%				
D3330	ENDODONTIC THERAPY MOLAR EXCLUDES FINAL RESTORATION	Yes		65%				
D3346	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-ANTERIOR	Yes		65%				
D3347	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-BICUSPID	Yes		65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D3348	RETREATMENT OF PREVIOUS ROOT CANAL THERAPY-MOLAR	Yes		65%				
D3351	APEXIFICATION / RECALCIFICATION INITIAL VISIT	Yes		65%				
D3352	APEXIFICATION / RECALCIFICATION INTERIM MEDICATION REPLACEMENT	Yes		65%				
D3353	APEXIFICATION / RECALCIFICATION FINAL VISIT	Yes		65%				
D3410	APICOECTOMY / PERIRADICULAR SURGERY ANTERIOR	Yes		65%				
D3421	APICOECTOMY / PERIRADICULAR SURGERY BICUSPID	Yes		65%				
D3425	APICOECTOMY / PERIRADICULAR SURGERY MOLAR	Yes		65%				
D3426	APICOECTOMY / PERIRADICULAR SURGERY EACH ADDITIONAL ROOT	Yes		65%				
D3450	ROOT AMPUTATION-PER ROOT	Yes		65%				
D3920	HEMISECTION INCLUDING ROOT REMOVAL W/O ROOT CANAL THERAPY	Yes		65%				
D4210	GINGIVECTOMY / GINGIVOPLASTY, 4 OR MORE CONT/BNDED TEETH PER QUAD	Yes	1 every 36 months	65%				
D4211	GINGIVECTOMY / GINGIVOPLASTY,1-3 CONT/BNDED TEETH PER	Yes		65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	QUAD							
D4240	GINGIVAL FLAP PROCEDURE, 4 OR MORE TEETH INCLUDING ROOT PLANING	Yes	1 every 36 months	65%				
D4249	CLINICAL CROWN LENGTHENING-HARD TISSUE	Yes		65%				
D4260	OSSEOUS SURGERY, 4 OR MORE CONT/BNDED TEETH PER QUAD	Yes	1 every 36 months	65%				
D4270	PEDICLE SOFT TISSUE GRAFT PROCEDURE	Yes		65%				
D4271	FREE SOFT TISSUE GRAFT PROC INCLUDING DONOR SITE SURGERY	Yes		65%				
D4273	SUBEPITHELIAL CONNECTIVE TISSUE GRAFT PROC, PER TOOTH	Yes		65%				
D4341	PERIODONTAL SCALING AND ROOT PLANING, FOUR OR MORE PER QUAD	Yes	1 every 24 months	45%				
D4342	PERIODONTAL SCALING AND ROOT PLANING, ONE TO THREE, PER QUAD	Yes	1 every 24 months	45%				
D4355	FULL MOUTH DEBRIDEMENT TO ENABLE COMP EVAL AND DIAGNOSIS	Yes	1 per lifetime	65%				
D4910	PERIODONTAL MAINTENANCE	Yes	4 in 12 maintenance combined with adult prophylaxis after the completion of active periodontal therapy	45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D5110	COMPLETE DENTURE MAXILLARY	Yes	1 every 60 months	65%				
D5120	COMPLETE DENTURE MANDIBULAR	Yes	1 every 60 months	65%				
D5130	IMMEDIATE DENTURE MAXILLARY	Yes	1 every 60 months	65%				
D5140	IMMEDIATE DENTURE MANDIBULAR	Yes	1 every 60 months	65%				
D5211	MAXILLARY PARTIAL DENTURE RESIN BASE	Yes	1 every 60 months	65%				
D5212	MANDIBULAR PARTIAL DENTURE RESIN BASE	Yes	1 every 60 months	65%				
D5213	MAXILLARY PARTIAL DENTURE CAST METAL WITH RESIN DENTURE BASE	Yes	1 every 60 months	65%				
D5214	MANDIBULAR PARTIAL DENTURE CAST METAL WITH RESIN DENTURE BASE	Yes	1 every 60 months	65%				
D5281	REMOVABLE UNILATERAL PART DENTURE ONE PIECE CAST METAL	Yes	1 every 60 months	65%				
D5410	ADJUST COMPLETE DENTURE-MAXILLARY	Yes		45%				
D5411	ADJUST COMPLETE DENTURE-MANDIBULAR	Yes		45%				
D5421	ADJUST PARTIAL DENTURE-MAXILLARY	Yes		45%				
D5422	ADJUST PARTIAL DENTURE-MANDIBULAR	Yes		45%				
D5510	REPAIR BROKEN COMPLETE DENTURE BASE	Yes		45%				
D5520	REPLACE MISSING OR BROKEN TEETH-COMPLETE DENTURE (EACH TOOTH)	Yes		45%				
D5610	REPAIR RESIN DENTURE BASE	Yes		45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D5620	REPAIR CAST FRAMEWORK	Yes		45%				
D5630	REPAIR OR REPLACE BROKEN CLASP	Yes		45%				
D5640	REPLACE BROKEN TEETH PER TOOTH	Yes		45%				
D5650	ADD TOOTH TO EXISTING PARTIAL DENTURE	Yes		45%				
D5660	ADD CLASP TO EXISTING PARTIAL DENTURE	Yes		45%				
D5710	REBASE COMPLETE MAXILLARY DENTURE	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5720	REBASE MAXILLARY PARTIAL DENTURE	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5721	REBASE MANDIBULAR PARTIAL DENTURE	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5730	RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)	Yes	1 in a 36 month period 6 months after the initial	45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
			installation					
D5731	RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5740	RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5741	RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5750	RELINE COMPLETE MAXILLARY DENTURE (LAB)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5751	RELINE COMPLETE MANDIBULAR DENTURE (LAB)	Yes	1 in a 36 month period 6 months after the initial installation	45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D5760	RELINE MAXILLARY PARTIAL DENTURE (LAB)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5761	RELINE MANDIBULAR PARTIAL DENTURE (LAB)	Yes	1 in a 36 month period 6 months after the initial installation	45%				
D5820	INTERIM PARTIAL DENTURE (MAXILLARY)	Not Covered						
D5821	INTERIM PARTIAL DENTURE (MANDIBULAR)	Not Covered						
D5850	TISSUE CONDITIONING (MAXILLARY)	Yes		45%				
D5851	TISSUE CONDITIONING (MANDIBULAR)	Yes		45%				
D6010	SURGICAL PLACEMENT OF IMPLANT BODY, ENDOSTEAL IMPLANT	Yes	1 every 60 months	65%				
D6012	SURGICAL PLACEMENT OF INTERIM IMPLANT BODY, ENDOSTEAL IMPLANT	Yes	1 every 60 months	65%				
D6040	SURGICAL PLACEMENT, EPOSTEAL IMPLANT	Yes	1 every 60 months	65%				
D6050	SURGICAL PLACEMENT, TRANSOSTEAL IMPLANT	Yes	1 every 60 months	65%				
D6053	IMPLANT SUPPORTED COMPLETE DENTURE	Yes		65%				
D6054	IMPLANT SUPPORTED PARTIAL DENTURE	Yes		65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D6055	IMPLANT CONNECTING BAR	Yes	1 every 60 months	65%				
D6056	PREFABRICATED ABUTMENT	Yes	1 every 60 months	65%				
D6058	ABUTMENT SUPPORTED PORCELAIN CERAMIC CROWN	Yes	1 every 60 months	65%				
D6059	ABUTMENT SUPPORTED PORCELAIN FUSED TO HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6060	ABUTMENT SUPPORTED PORCELAIN FUSED TO BASE METAL CROWN	Yes	1 every 60 months	65%				
D6061	ABUTMENT SUPPORTED PORCELAIN FUSED TO NOBLE METAL CROWN	Yes	1 every 60 months	65%				
D6062	ABUTMENT SUPPORTED CAST HIGH NOBLE METAL CROWN	Yes	1 every 60 months	65%				
D6063	ABUTMENT SUPPORTED CAST BASE METAL CROWN	Yes	1 every 60 months	65%				
D6064	ABUTMENT SUPPORTED CAST NOBLE METAL CROWN	Yes	1 every 60 months	65%				
D6065	IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN	Yes	1 every 60 months	65%				
D6066	IMPLANT SUPPORTED PORCELAIN FUSED TO HIGH METAL CROWN	Yes	1 every 60 months	65%				
D6067	IMPLANT SUPPORTED METAL CROWN	Yes	1 every 60 months	65%				
D6068	ABUTMENT SUPPORTED RETAINER PORC/CERAMIC FXD PART DENTURE	Yes	1 every 60 months	65%				
D6069	ABUTMENT RETAINER PORC FUSED HIGH NOBLE METAL	Yes	1 every 60 months	65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	FXD PART DENT							
D6070	ABUTMENT RETAINER PORC FUSED BASE METAL FXD PART DENTURE	Yes	1 every 60 months	65%				
D6071	ABUTMENT RETAINER PORC FUSED NOBLE METAL FXD PART DENTURE	Yes	1 every 60 months	65%				
D6072	ABUTMENT RETAINER CAST HIGH NOBLE METAL FXD PART DENTURE	Yes	1 every 60 months	65%				
D6073	ABUTMENT RETAINER PREDOMINANTLY BASE METAL FXD PART DENT	Yes	1 every 60 months	65%				
D6074	ABUTMENT SUPPORTED RETAINER CAST NOBLE METAL FXD PART DENT	Yes	1 every 60 months	65%				
D6075	IMPLANT SUPPORTED RETAINER CERAMIC FXD PART DENTURE	Yes	1 every 60 months	65%				
D6076	IMPLANT RETAINER PORC FUSED HIGH NOBLE METAL FXD PART DENT	Yes	1 every 60 months	65%				
D6077	IMPLANT SUPPORTED RETAINER CAST METAL FXD PART DENT	Yes	1 every 60 months	65%				
D6078	IMPLANT/ABUTMENT FXD PART DENT COMPLETE EDENTULOUS ARCH	Yes	1 every 60 months	65%				
D6079	IMPLANT/ABUTMENT FXD PART DENT PART EDENTULOUS ARCH	Yes	1 every 60 months	65%				
D6080	IMPLANT MAINTENANCE PROCEDURES	Yes	1 every 60 months	65%				
D6090	REPAIR IMPLANT PROSTHESIS, BY REPORT	Yes	1 every 60 months	65%				

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		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D6091	REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT	Yes	1 every 60 months	65%				
D6095	REPAIR IMPLANT ABUTMENT, BY REPORT	Yes	1 every 60 months	65%				
D6100	IMPLANT REMOVAL, BY REPORT	Yes	1 every 60 months	65%				
D6190	RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT	Yes	1 every 60 months	65%				
D6210	PONTIC CAST HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6211	PONTIC CAST PREDOMINANTLY BASE METAL	Yes	1 every 60 months	65%				
D6212	PONTIC CAST NOBLE METAL	Yes	1 every 60 months	65%				
D6214	PONTIC TITANIUM	Yes	1 every 60 months	65%				
D6240	PONTIC PORCELAIN FUSED TO HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6241	PONTIC PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Yes	1 every 60 months	65%				
D6242	PONTIC PORCELAIN FUSED TO NOBLE METAL	Yes	1 every 60 months	65%				
D6245	PONTIC PORCELAIN/CERAMIC	Yes	1 every 60 months	65%				
D6545	RETAINER CAST METAL RESIN BONDED FXD PROSTHESIS	Yes	1 every 60 months	65%				
D6548	RETAINER PORCELAIN/CERAMIC RESIN BONDED FXD PROSTHESIS	Yes	1 every 60 months	65%				
D6740	CROWN PORCELAIN/CERAMIC	Yes	1 every 60 months	65%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D6750	CROWN PORCELAIN FUSED TO HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6751	CROWN PORCELAIN FUSED TO PREDOMINANTLY BASE METAL	Yes	1 every 60 months	65%				
D6752	CROWN PORCELAIN FUSED TO NOBLE METAL	Yes	1 every 60 months	65%				
D6780	CROWN 3/4 CAST HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6781	CROWN 3/4 PREDOMINANTLY BASE METAL	Yes	1 every 60 months	65%				
D6782	CROWN 3/4 CAST NOBLE METAL	Yes	1 every 60 months	65%				
D6783	CROWN 3/4 PORCELAIN/CERAMIC	Yes	1 every 60 months	65%				
D6790	CROWN FULL CAST HIGH NOBLE METAL	Yes	1 every 60 months	65%				
D6791	CROWN FULL CAST PREDOMINANTLY BASE METAL	Yes	1 every 60 months	65%				
D6792	CROWN FULL CAST NOBLE METAL	Yes	1 every 60 months	65%				
D6930	RECEMENT FIXED PARTIAL DENTURE	Yes		45%				
D6973	CORE BUILDUP FOR RETAINER INCLUDING ANY PINS	Yes	1 every 60 months	65%				
D6980	FIXED PARTIAL DENTURE REPAIR, BY REPORT	Yes		45%				
D7140	EXTRACTION ERUPTED TOOTH OR EXPOSED ROOT	Yes		45%				
D7210	SURGICAL REMOVAL OF ERUPTED TOOTH	Yes		45%				
D7220	REMOVAL OF IMPACTED TOOTH SOFT TISSUE	Yes		45%				
D7230	REMOVAL OF IMPACTED	Yes		45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	TOOTH PARTIALLY BONY							
D7240	REMOVAL OF IMPACTED TOOTH COMPLETELY BONY	Yes		45%				
D7241	REMOVAL OF IMPACTED TOOTH COMPLETE BONY W/ UNUSUAL SURG COMP	Yes		45%				
D7250	SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)	Yes		45%				
D7270	TOOTH REIMPLANTATION/STABILIZATION OF ACCIDENTALLY EVULSED/DISPLACED TOOTH	Yes		45%				
D7280	SURGICAL ACCESS OF AN UNERUPTED TOOTH	Yes		45%				
D7285	BIOPSY OF ORAL TISSUE HARD	Not Covered						
D7286	BIOPSY OF ORAL TISSUE SOFT	Not Covered						
D7310	ALVEOLOPLASTY WITH EXTRACTIONS (4 OR MORE TEETH/SPACES) PER QUAD	Yes		45%				
D7311	ALVEOLOPLASTY W/ EXTRACTION (1-3 TEETH/SPACES) PER QUAD	Yes		45%				
D7320	ALVEOLOPLASTY W/O EXTRACTIONS (4 OR MORE TEETH/SPACES) PER QUAD	Yes		45%				
D7321	ALVEOLOPLASTY W/O EXTRACTION (1-3 TEETH/SPACES) PER QUAD	Yes		45%				
D7460	REMOVAL OF BENIGN LESION UP TO 1.25 cm	Not Covered						
D7471	REMOVAL OF LATERAL EXOSTOSIS	Yes		45%				
D7510	INCISION AND DRAINAGE	Yes		45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	ABSCESS, INTRAORAL SOFT TISSUE							
D7530	REMOVAL OF FOREIGN BODY	Not Covered						
D7610	UPPER OPEN REDUCTION	Not Covered						
D7620	UPPER CLOSED REDUCTION	Not Covered						
D7630	LOWER OPEN REDUCTION	Not Covered						
D7640	LOWER CLOSED REDUCTION	Not Covered						
D7650	MALAR AND/OR ZYGOMATIC ARCH-OPEN REDUCTION	Not Covered						
D7810	TMJ OPEN REDUCTION	Not Covered						
D7820	TMJ CLOSED REDUCTION	Not Covered						
D7840	CONDYLECTOMY	Not Covered						
D7850	SURGICAL DISCECTOMY	Not Covered						
D7860	ARTHROTOMY	Not Covered						
D7870	ARTHROCENTESIS	Not Covered						
D7880	OCCLUSAL ORTHOTIC DEVICE, BY REPORT	Not Covered						
D7910	SUTURES OF RECENT WOUNDS UP TO 5 cm	Yes		45%				
D7911	COMPLICATED SUTURES UP TO 5 cm	Not Covered						
D7940	OSTEOPLASTY FOR DEFORMITIES	Not Covered						
D7971	EXCISION OF PERICORONAL GINGIVA	Yes		45%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D7980	SIALOLITHOTOMY	Not Covered						
D8010	LIMITED ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	Yes	Limited to children up to age 19	50%				
D8020	LIMITED ORTHODONTIC TREATMENT OF THE TRANSITIONAL DENTITION	Yes	Limited to children up to age 19	50%				
D8030	LIMITED ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION	Yes	Limited to children up to age 19	50%				
D8050	INTERCEPTIVE ORTHODONTIC TREATMENT OF THE PRIMARY DENTITION	Yes	Limited to children up to age 19	50%				
D8060	INTERCEPTIVE ORTHODONTIC TREATMENT OF TRANSITIONAL DENTITION	Yes	Limited to children up to age 19	50%				
D8070	COMPREHENSIVE ORTHODONTIC TREATMENT TRANSITIONAL DENTITION	Yes	Limited to children up to age 19	50%				
D8080	COMPREHENSIVE ORTHODONTIC TREATMENT ADOLESCENT DENTITION	Yes	Limited to children up to age 19	50%				
D8210	REMOVABLE APPLIANCE THERAPY	Yes	Limited to children up to age 19	50%				
D8220	FIXED APPLIANCE THERAPY	Yes	Limited to children up to age 19	50%				
D8660	PRE-ORTHODONTIC TREATMENT VISIT	Yes	Limited to children up to age 19	50%				
D8670	PERIODIC ORTHODONTIC TREATMENT VISIT	Yes	Limited to children up to age 19	50%				

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
D8680	ORTHODONTIC RETENTION	Yes	Limited to children up to age 19	50%				
D9110	PALLIATIVE TREATMENT OF DENTAL PAIN	Yes		0%				
D9220	DEEP SEDATION/GENERAL ANESTHESIA FIRST 30 MIN	Yes		45%				
D9221	DEEP SEDATION/GENERAL ANESTHESIA- EACH ADD 15 MIN	Yes		45%				
D9241	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA FIRST 30 MIN	Yes		45%				
D9242	INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA EACH ADD 15 MIN	Yes		45%				
D9310	CONSULTATION	Yes		45%				
D9420	HOSPITAL VISIT	Not Covered						
D9610	THERAPEUTIC DRUG INJECTION	Yes		45%				
D9920	BEHAVIOR MANAGEMENT, BY REPORT	Not Covered						
D9930	TREATMENT OF COMPLICATIONS (POST SURGICAL) UNUSUAL CIRCUMSTANCES, BY REPORT	Yes		45%				
D9940	OCCLUSAL GUARD, BY REPORT	Yes	1 in 12 months for age 13 and older	65%				
D9951	OCCLUSAL ADJUSTMENT LIMITED	Not Covered						

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay
	OTHER SERVICES							

Procedure Code	Standard Description	FEHBP STANDARD OPTION			RESPONDER PLAN			
		Dental Services & Supplies	Limitation	Co-Insurance	Covered	Limitation	Co-Insurance	Co-Pay